

UNIVERSITY OF GHANA

**COLLEGE OF HUMANITIES
SCHOOL OF SOCIAL SCIENCES**



**VIOLENCE AND DISCRIMINATION AMONG PERSONS WITH DISABILITY: A
STUDY OF TWO REGIONS IN GHANA.**

BY

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPhil IN
CLINICAL PSYCHOLOGY DEGREE.**

DEPARTMENT OF PSYCHOLOGY



JULY, 2019

DECLARATION

This is to certify that this thesis entitled “Violence and Discrimination among Persons with Disability: A Study of Two Regions in Ghana.” is the result of research carried out by DANIEL AGYEI-KYEREMEH towards the award of the MPhil Clinical Psychology Degree in the Department of Psychology, University of Ghana.

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ABSTRACT

Evidence indicates that persons with disability are more likely to be victims of violence and discrimination relative to people without disability. The Ghana Statistical Service (GSS) estimates the number of persons with disability in Ghana to be about 3% of the population. Evidence from the existing literature consistently indicates that discrimination and violence are negatively associated with subjective well-being. However, there are few studies in Ghana that have examined the forms of violence and effects on the psychological well-being of persons with disability. The current study sought to examine violence and discriminations among persons with disability in Ghana. The hypotheses of the study were tested using hierarchical regression, moderation and mediation in SPSS and PROCESS MACRO. Findings of the study indicated that persons with disabilities are at an increased risk of violence and discrimination when compared to those without any form of disability. Form of disability, visibility and place of residence were identified as significant predictors of violence and discrimination among persons with disability. The findings also identified violence and discrimination as significant predictors of psychological health. Factors such as religiosity and gender were found to be moderators of the relationship between violence and discrimination and psychological health. Additionally, the study found social support to be a mediator of the relationship between violence and discrimination and psychological health. The study provides evidence that a person's environment has a huge impact on the experience and extent of disability. Limitations of the study, as well as implications, are discussed.

DEDICATION

This work is dedicated to the Almighty God for His grace and mercies. This work is also dedicated to my family especially my parents, Very Rev. and Mrs Daniel Agyei.

ACKNOWLEDGEMENT

My special thanks go to God almighty, the giver of life for His love and mercy upon my life. I wish to thank my supervisors; Dr Annabella Osei-Tutu and Dr Irene Kretchy for their guidance and immense support throughout this research. I would like to also extend a special thanks to Dr Adotey Anum for his time and support throughout this research.

I am also grateful to James Aryee for his support, especially during the data collection stage of this research.

I would like to acknowledge that this thesis is part of a collaborative project with my supervisor Dr Annabella Osei-Tutu.

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LIST OF ABBREVIATIONS

WHO	WORLD HEALTH ORGANISATION
WB	WORLD BANK
GSS	GHANA STATISTICAL SERVICE
UN	UNITED NATIONS
ICF	INTERNATIONAL CLASSIFICATION OF FUNCTIONING

CHAPTER ONE

INTRODUCTION

1.1. Background

According to a World Health Organization (WHO) (2011) and a World Bank (WB) report (2011), people living with disabilities globally are more than one billion. According to the report, out of the over one billion persons living with a disability, 80% live in developing countries. The number of people with disability is expected to grow due to ageing populations and a rise in chronic diseases and mental illness (Officer & Shakespeare, 2013). The world report on disability indicates that persons with disability are more likely to be underprivileged in various domains including social exclusion, unemployment and poverty (WHO & WB, 2011).

The Ghana Statistical Service (GSS), based on the 2010 Ghana population census, estimates the number of persons with disability in Ghana to be about three per cent of the population. According to the survey, females with disability (3.1%) are slightly more than males with disability (2.9%). The survey indicated that persons with disability living in rural are more than those in urban areas. The Ghana Statistical Service report on disability argues that persons with disability continue to face stigma, marginalisation, and discrimination (GSS, 2014).

Disability is a complex phenomenon with no universally accepted definition (WHO & WB, 2011). Different models of conceptualisations have however been propounded in an attempt to explain disability. One of the earliest models of disability is the religious model and can be found in many religious traditions, including the Christian tradition and local traditional worships (Pardeck & Murphy, 2012). The basic tenet of this model of disability is that disability is viewed as a punishment from God for a particular sin or sins that the person with a disability or a relative may have committed. Evidence of this model has been found in Ghana (Agbenyega, 2003; Avoke, 2002; Fefoame, 2009), for example, some communities believe giving birth to a child with an intellectual

disability is a curse from the gods (Fefoame, 2009). Disability has long been associated with curses, evil, magic in Ghana (Avoke, 2002). It is often seen as a punishment from a supreme being for a sin that may have been committed by a parent, a family member or an ancestor. These beliefs often lead to demeaning labelling which mostly lead to negative perceptions, discrimination and abuse of the rights of persons with disabilities in Ghana.

Another model that offers an explanation of what disability is, is known as the biological model. This model sees biological impairment as the major cause of disability. This perspective mostly divides the types of disability according to the specific impairments such as mental, cognitive, emotional, physical, sensory and some combination of these. In this model of disability is seen as a medical condition that is within the person. It is considered as a defect in or failure of a bodily system such is inherently abnormal and pathological (Olkin, 1999). Interventions under this model focus on curing and relieving the discomfort of the physical condition to the largest extent possible (Olkin, 1999). The individual with a disability under this model is seen as a patient or learner being assisted by a trained professional. This model to some extent portrays persons with disability as 'incomplete', hence are often termed as handicapped, retarded or cripple (Creamer 2009).

Social model was also developed as an alternative to the biomedical model of disability. This model identifies disability in the systems of society instead of looking at it as inherent to the individual; that is, services for individuals with disabilities are focused on modifying some parts of society to ensure that persons with disability are given the chance to participate fully in all spheres of social life (Oliver & Barnes, 2012). This model, therefore, views disability as an imposition from the society on persons with impairment, hence suggest that the most appropriate solution must be aimed at changing society instead of focusing on cure and adjustment of the individual (Barnes, Mercer, & Shakespeare 2010).

The emphasis of this model is on societal factors that serve as barriers to equal opportunities for people with impairments instead of the individual (WHO, 2002a). For example, visual impairment will not become a disability when a person with this impairment is provided with adequate support, aids and legal rights. This perspective sees disability as a phenomenon caused by failures in the societal system to provide equitable services for all persons with different abilities. The social model, therefore, sees the provision of robust social and physical support including changing of attitudes towards persons with impairments and provision of physical structures to help people with impairment in their social environment.

The models of disability have changed over time from the medical model to the biopsychosocial model, with current service provision being based on the WHO's International Classification of Functioning, Disability and Health (ICF) (WHO, 2002a). The ICF model is meant to serve as a universal classification system that can be applied to various levels of health and not limited to only disability. Disability is defined by ICF as the outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives (WHO, 2001).

The biopsychosocial model considers disability as a fluid thing which exists at sometimes but not at other times in a person's life. That is a person can be said to have a disability in some situations but not in other situations. To put it in another way, disability is not a fixed existence. The complexity of disability means it can be best understood by integrating the various perspectives. Hence, disability according to the biopsychosocial approach is the interaction between the individual, the individual's condition, and the environment (WHO & WB, 2011). Interaction under this model means that disability is not seen as an attribute of the person but rather results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their social inclusion and participation.

Social inclusion and participation can be achieved by tackling the barriers which face people with disabilities in their daily lives. This change in paradigm led to the adoption of the United Nations Convention on the Rights of Persons with Disability (United Nations, 2006) by most member states. The Convention on the rights of persons with disabilities (CRPD) seeks to ensure the protection and full participation of persons with disabilities in society. This shows the global community's commitment to the course of people with disability.

The presence of a disability does not lead to negative psychological outcomes but it is rather mostly triggered by external influences (Dunn, 2011). In most cases, there is the presence of fundamental attribution error where people focus mostly on internal characteristics (inadequacies) of persons with disabilities rather than external factors such as disability-based violence and discriminations perpetrated against a person with a disability (Dunn, 2011). Historically, persons with disability have often been subjected to exclusion or pity by non-disabled persons in their communities (Hunt et al., 2018). There have been several reports of abuse and neglect of persons with disability. Recent evidence indicates that individuals with disabilities are more likely to experience violence and discrimination relative to people without disability (WHO & WB, 2011). Both men and women with various forms of disabilities also seem to be at higher risk of being exposed to violence (Jones et al., 2012; WHO & WB, 2011).

Violence against individuals with disabilities may be due to several factors including exclusion to education and employment, reduced physical and emotional defences, inability to communicate well thereby preventing them from reporting violence, societal stigma, and discrimination (Jones et al., 2012). Disability has also been found to lead to an increase in the level dependency on others due to the need for assistance (Thomas, Joshi, Wittenberg, & McCloskey, 2008). Physical, emotional, and financial dependency on people who provide them with assistance exposes persons with disability to different forms of abuse and its negative impact on their mental health (Curry et al., 2009). Living a life that of devoid of violence is a basic human right enshrined in the Universal

Declaration of Human Rights, and is key to the Sustainable Development Goals (UN, 2015).

A number of policies and interventions have been introduced to protect the right of persons with disability. For example, Ghana is a signatory to international agreements including the UN Convention on the rights of people with disability (2006) and African decade of the disabled people (2009-2010). In addition, Ghana in 2006 passed the Person with Disability Act (715). These actions clearly show that efforts are being made in Ghana to safeguard the right of persons with disability and to promote and respect their dignity. Also, recent media reports indicate that efforts are being made to improve the lives of persons with disability. For example, 1000 women with disabilities were given two million Ghana Cedis to support their businesses. The beneficiaries will be required to pay 50% of the amount granted to them after a period of time (Britwum, 2019). In a similar development, fifty per cent of people employed to collect toll at various points across the country were persons with physical disabilities (Yarkor-Dagbah, 2019). Persons with disabilities are also eligible for disability grants from the district common fund. Three per cent of district common fund is made available yearly to each district, municipal or metropolitan assembly in Ghana. This is to be made available as a grant to persons with disability (Amenuveve, 2017). These are all measures to help improve the livelihood of persons with disabilities.

Despite these efforts, persons with disability in Ghana are still faced with difficulties like violence and discrimination. In Ghana, persons with disabilities have been identified as an “impoverished marginalised group” (Voice Ghana, 2014). Studies have identified persons with disability in Ghana to be in extreme poverty, abused and discriminated against, and excluded from family, community and the national level (Mensah, Williams, Atta-Ankomah, & Mjomba, 2008; Voice Ghana, 2014). Discrimination is evident in some cultural practices for instance, most Akan speaking Ghanaians prevents people with physical defects from being enstooled as chiefs (Sarpong, 1974). The negative perception is obvious from the fact that a chief who becomes epileptic is ‘destooled’ (Sarpong, 1974).

When disability combines with factors such as unemployment and poverty, it renders individuals vulnerable to various forms of discrimination and violence which may negatively affect their psychological well-being (Naami, Hayashi & Liese, 2012). Research has shown that violence and discrimination can have a deleterious effect on the victims' mental and physical health as well as their socio-occupational functioning (Kavanagh et al., 2013; Thornicroft et al., 2007). According to Baffoe (2013), discrimination may lead to ridicule and devaluation a person's self-worth thereby exposing such individuals to challenges in several domains of life including access to housing, getting and maintaining regular employment, access to education, involvement in meaningful relationships and enjoyment of quality of life. This places persons with disability at a social disadvantage in terms of income, knowledge, prestige and social connections.

A meta-analytic review has shown that violence and discrimination have a negative impact on the well-being of people in all kinds of disadvantaged groups (Schmitt, Branscombe, Postmes, & Garcia, 2014). Schmitt et al. (2014) also found differences between the effect of discrimination varied systematically according to the study characteristics. Kelly, Kelly, and Macdonald (2016) found that discrimination was negatively associated with subjective well-being among persons with disabilities. Factors such as society's perception of persons with disabilities and attitudes shown toward them have also been found to be associated with low subjective well-being (Kelly et al., 2016). Violence has been linked to health outcomes both immediate and long term, including injuries, physical and mental health problems, substance abuse, and death (World Health Organization, 2002).

Discrimination has been found to be associated with a number of negative health outcomes such as stress, depression, and stress (Stansfeld et al., 2017). There is overwhelming evidence that discrimination and violence can increase the level of stress (Nadimpalli et al. 2016; Stansfeld et al., 2017; Straus, 2017). Again, discrimination-related stress has been found to have an association

with mental health specifically, anxiety and depression (Anderson, 2013). According to Jang, Chiriboga, and Small (2008), irrespective of what may have caused it, the experience of discrimination and violence is linked with a number of adverse health outcomes, such as stress, anxiety and depression. A lot of studies have documented the detrimental effect of abuse on persons without disability, however, the same cannot be said about persons with disability (Hassouneh-Phillips, 2005).

1.2. Problem statement

There is evidence that persons with disability are disproportionately vulnerable to violence and are more likely to be discriminated against (Jones et al. 2012). However, there are few studies that compare the risk of violence among various disability groups. Although there are several reports of a higher rate of violence among persons with disabilities, there are no clear findings on the form of violence experienced and role of factors such as the type and severity of the disability.

Studies have provided qualitative evidence of discrimination and violence against, and negative attitudes towards persons with disability in Ghana (Anum, 2011; Kassah, Kassah, & Agbota, 2014; Naami, & Hayashi, 2012), however, there is paucity of literature on the effect of discrimination and violence on the psychological well-being of individuals with disability in Ghana. A few studies in Ghana have also looked at how people faced with adversities such as disabilities and discrimination and/or violence are still able to do well. There is, therefore, the need to look at the factors such as religiosity and social support that may strengthen persons with disability in the face of stressors such as violence and discrimination.

Also, although there have been studies on the role of social support among people who are faced with adversities (Afun, 2016; Asante, 2012; Atefoe, 2013), few have looked at its role in mediating the relationship between discrimination and violence, and psychological well-being. Likewise, to the best of my knowledge, factors such as religion and self-worth are yet to be quantitatively

explored among persons with disabilities in Ghana. There is also, the need to understand what the consequences of discriminatory actions and violence towards persons with disability are, in order to be able to fully provide the needed assistance to victims of such acts.

Additionally, even though there are studies on the experience of abuse and discrimination among individuals with disabilities in Ghana which confirms their existence through qualitative studies (Baffoe, 2014; Dako-Gyeke & Asumang, 2013; Kassah, Kassah, & Agbota, 2014), to the best of my knowledge there are no quantitative studies to give a picture about the magnitude of the problem. There is, therefore, the need to understand the extent to which discrimination and violence, are common among persons with disability.

Judge, Menne, and Whitlatch (2009), argues that factors that affect an individual's well-being are interrelated. To this end, there is the need to examine the factors that are related to violence and discrimination among persons with disability and nature of the relationships in order to inform intervention strategies. Although some studies have been conducted on some of these factors in other countries, there is the need to explore the interacting factors that are related to violence and discrimination, and psychological health among persons with disabilities in Ghana.

1.3. Aim and objectives

The aim of this study is to examine violence and discrimination experienced by persons with disabilities and its relationship with psychological health and well-being.

The specific objectives are:

1. To assess the relationship between violence and discrimination, and psychological health and well-being
2. To determine the forms of violence and discriminations common among persons with disability in Ghana.

3. To ascertain predictors of violence and discrimination among persons with disabilities.
4. To examine factors that moderate the relationship between violence and discrimination, and psychological health and well-being.

1.4. The relevance of the study

Most studies report a single measure of violence (either overall interpersonal or intimate partner violence); however, the current study seeks to collect data on the different types of interpersonal violence (physical, sexual, emotional, etc) as the risk of each may vary for different population groups.

This study will provide an overview of the different forms of violence and discrimination experienced by persons with disabilities in Ghana. The study will also help us understand the role of violence and discrimination experienced by persons with disability on their psychological well-being. This will help develop specific strategies to prevent violence and discrimination.

This study will help us understand the processes at work regarding the impact of violence and discrimination among persons with disability on their mental health. This will in turn help develop culturally relevant strategies and interventions that will mitigate the consequences of violence and discrimination on persons with disabilities. This will invariably help improve their health and quality of life.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter situates the current study within the context of relevant literature on violence and discrimination among persons with disabilities. The theory and models that served as the framework for the study are discussed first. Then a review of related studies takes a critical look at the relevant studies taking into consideration the study objectives.

2.2 Theoretical Framework

The theory of social identity and the stress process model were reviewed to help conceptualize this study. The social identity theory was used to help explain the causes of discrimination and violence, while the stress model will help explain the complex relationship between stressors such as violence and discrimination, potential moderators and mediators, and psychological health.

2.2.1 The Social Identity Theory

Social Identity theory was first propounded by Tajfel (1978) and developed further by Tajfel and Turner (1979). Social identity was developed as an aspect of a person's self-concept which is as a result of the person being a member of a group together with their evaluative, emotional and other psychological factors. The social identity theory was propounded to analyse intergroup relations and social conflict. This theory proposes that people have the need to have a positive social identity or a positive distinctiveness. This is done through positive comparisons for in-group members and negative comparison for out-group members.

The theory of social Identity has three main general assumptions. The first is that individuals endeavour to attain or sustain a positive social identity. The second assumption is that positive social identity is mostly based on favourable comparisons that can be made between an in-group and a relevant out-group, in this case, there is a positive perception of the in-group which

differentiates it from the relevant out-group. The final assumption is that when a person is not satisfied with his or her social identity, the person will strive to either leave their current group and/or effect changes that will make their current group more relevant and different. The basic hypothesis for this theory, therefore, is that the urge for an individual to evaluate his group favourably through in-group/outgroup comparisons is lead social groups to try to make themselves distinct from each other (Tajfel & Turner, 1979).

Tajfel (1978) summarized social identity and grouped social identity processes into the following sequence social-categorization, social identity, social comparison and positive distinctiveness. Social categorizations tend to define individuals' place in society, which may then be self-internalised. This together with the emotional importance attached to it, provide people with social identities. There have been a number of studies that show that the mere social categorization into groups was enough for discrimination to occur. According to this theory, people tend to allocate more resources to individuals who are in the same group as they are (in-group) relative to people who are considered members of a group they do not belong to (outgroup).

According to Tajfel and Turner social categorization as a cognitive tool segments, classifies, and order the social environment, and thus enables the individual to individual to undertake many forms of social action (1979). They argued that not only does social categorizations systemize the social world but also establish and give definition to a person's place in society. This gives members of social groups an identification of themselves in social terms. The theory of social identity again posits that identifications to a great degree define a person as similar to or different, as better or worse than, members of other groups (Tajfel & Turner, 1979). Tajfel and Turner (1979) further argued that stereotyping is based on the tendency to group things together. In categorizing, people tend to exaggerate the differences between the groups and the differences and the similarities of things within the same group.

This theory suggests that when a person sees himself as being a member of a group, that is an in-group for the person. Other comparable groups that people do not identify with are known as out-group. People without disabilities may see themselves as members of a group (in-group) and persons with disabilities as members of another group (out-group). Tajfel argued that being placed into an "us" and "them" situation changes peoples' behaviour and makes them behave differently towards those who are not in their group (Brewer & Hewstone, 2004). According to Augoustinos, Walker, and Donaghue, (2014), a number of studies have indicated that the mere perception of belonging to two different groups is enough to trigger in-group favouritism and discriminate against the outgroup. Thus, phenomena such as stereotyping and person perception rest on social categorization. In this case, people without disabilities' negative beliefs about persons with disabilities may lead them to discriminate against them. Based on this theory, the perceived differences between persons with disability and persons without disability such as sensory capacities, intellectual capacities or physical bodies are likely to be exaggerated.

In the case of Ghana, for example, Avoke (2002) found that most Ghanaian communities believe that children with intellectual disability are 'children of the rivers and forest' (P.773). Fefoame (2009) also observed that some traditional societies in Ghana believe that giving birth to a child to with disability is a curse or punishment from the gods. This creates the impression that persons with disability are "unclean" and as such are treated differently. These beliefs may foster negative attitudes towards people with disability. These beliefs invariably shape the way people without disability perceive persons with disability and this may help explain why they may discriminate or be violent towards them.

2.2.2 Stress Process Model

There is no single theory that sufficiently explains the relationship between stress, moderators and mediators and health. However, the stress process model integrates multiple levels of

available resources and stressors at the individual, family, and community level with the aim of predicting mental health outcomes.

This theory was propounded by Pearlin, Mullan, Semple, and Skaff, (1990) to explain the relationship between stress and mental health. The theory is based on the premise that one's exposure to stressors and availability of resources to cope arises out of the environment. They argue that risk and protective factors are socially distributed, with those who are more vulnerable and disadvantaged more being more prone to stressors with fewer social and personal resources such as social support and self-esteem. The theory posits that exposure to stressors coupled with low levels of protective factors leads to negative mental health outcomes.

The protective resources may themselves be affected by stressors thereby becoming a mediator between stressors and mental health (McLeod, 2012). For example, if a person loses trust in people due to sexual violence, it may affect the person's social relationships which may, in turn, affect their mental health. The protective factors can also be moderators of the relationship between stressors and psychological health, that is factors that influence the relationship between stressors and psychological health.

One major assumption of this theory is that factors that affect an individual's well-being are interrelated (Pearlin, 1999). Among the factors that come together are the social statutes of the person, the prevailing circumstances of the persons daily life, exposure to stressors such as violence and discrimination and these are manifested in the individual's psychological and bodily functioning. As a result of the interrelatedness of these factors, a change in one can lead to changes in the others, thereby setting in motion chains of effect. According to those who propounded the theory, it is because of this interconnectedness among the significant factors and the chain of effect that made them refer to this model as a process (Pearlin, 1999). In the

case of persons with disabilities, the process begins when they interact with persons in society and their environment with the interaction either having a positive or negative impact on their psychological health.

2.3 Review of Related Studies

This sub-section presents empirical studies that have been conducted on violence and Discrimination among persons with disabilities as well as the impact of violence and discrimination on psychological health and well-being of persons with disabilities. This helps to appreciate the depth and breadth of research on violence and discrimination among persons with disabilities around the world and in Ghana.

2.3.1 Predictors of Violence and Discrimination

Persons with disabilities are more likely to experience social exclusion, unemployment and abuse and other forms of discrimination (Kavanagh et al, 2013) which can lead to disparities in socioeconomic status. This, in turn, can lead to dependency which can ultimately expose persons with disability to various forms of violence and discriminations. Although all groups of socioeconomic status are exposed to violence and discrimination, persons with low socioeconomic status are at an increased risk (Santiago, Wadsworth, & Stump, 2011). It has been found that both Discrimination and low socioeconomic have long-term effects on individuals' psychological well-being (Huynh & Fuligni, 2010).

According to Jones et al (2012), there are several factors that predict violence and discrimination among persons with disabilities. In a meta-analysis of 17 studies on violence and disability, Jones and his colleagues (2012) confirmed that violence and discrimination, are more common among children with disabilities as compared to those without disabilities. In like manner. Hughes and his colleagues conducted a meta-analysis of 27 studies and found that experience of violence in the past year was high among adults with disabilities when compared

to adults without disabilities (Hughes et al., 2012). Hughes et al. also found that persons with mental disabilities are at more risk of violence when compared to persons without a disability. Despite this finding, there are few studies that have attempted to identify the specific type of violence experienced and the effects of factors such as the specific type of disability, visibility and the severity of a disability. Some disabilities are obvious to see while others are not so apparent. There is a tendency for persons with very visible disability to be exposed to disability-related discrimination (Dammeyer & Chapman, 2018). Safi lios-Rothschild (1970) argued that the more visible a disability is, the more likely it is to trigger a negative attitude. He also pointed out that the more severe a disability is, the more likely it will be negatively perceived.

Researchers have identified gender as a predictor of several forms of abuse. The effects of disability on women is disproportionately higher WHO (2015). According to the World Health Organization (2015), women and girls are at increased risk of experiencing double discrimination, which includes gender-based violence, abuse and marginalization. For example, Dammeyer and Chapman (2018) found that there was a significant difference in the type of violence or discrimination experienced; while men with disabilities are more likely to report physical violence, women are more likely to report sexual violence, humiliation and discrimination. Kassah et al. (2014) also found that women with disabilities in Ghana are faced with different forms of abuse such as social, physical, verbal and sexual abuse. They argued that this could be attributed to cultural beliefs. A similar qualitative study by Opoku et al. (2016) in Ghana which found that most the women who participated in the study had experienced sexual violence and this experience was coupled with other challenges such as poverty, social isolation and unemployment. According to Opoku et al. (2016), sexual violence often results in unwanted, pregnancies, divorce and rejection which further compound the challenges facing women with disabilities.

According to the World Health Organisation, access to education is vital in overcoming barriers such as violence and discrimination faced by persons with disabilities (WHO, 2011). However, according to Baffoe (2013), persons with disability are seen in our societies as people who need to be supported to live rather than empower them to live. This perception may cause families to deny them access to quality education.

Gartrell et al. (2017) found that the rights of women with disability in rural areas are unduly undermined by several socio-cultural, physical and psychological factors within their environment. These factors include gender, impairment, poverty, unemployment and rurality and lack of social support when compared to their peers in urban areas. Bock (2015) also found that in rural communities, women with disabilities are faced with several challenges such as lack of employment opportunities, educational opportunities, lack of social services, social isolation as well as traditional challenges associated with gender. In contrast, a study by Fiasorgbor and Ayagiyire (2015) in northern Ghana found that perception and attitudes towards persons with disabilities among rural residents were favourable. This was in spite of the several challenges facing persons with disability in rural. These findings suggest that persons with disabilities in rural areas are at an increased risk of violence and discrimination as compared to their colleagues in peri-urban and urban communities.

2.3.2 Protective Factors against Violence and Discrimination

Although experiences of violence and discriminations can have a negative impact on individuals with disabilities, there are several protective factors that may buffer the deleterious impact of these negative experiences on the psychological health and well-being of individuals with disabilities. Some of these factors are discussed below.

A review of studies on religion and psychological health by Weber and Pargament (2014) suggested that most studies generally found a positive relationship between the two. Generally, most studies on religion and mental health have found a positive relationship between the two

(Weber & Pargament, 2014). Religion has been found to moderate the relationship between stressors and psychological outcomes (Vash & Crewe, 2003). For example, prayers and other religious activities may serve as safe behaviours that may help in coping with unpleasant or traumatic experiences. Also, there are several positive emotions that may be associated with well-being like gratitude, reverence, hope and awe which are significant aspects of religious teachings and experiences (Rosmarin, Krumrei, & Andersson, 2009). Again, according to Marini and Graf (2011), individuals who believe in God or a spiritual power are more likely to have a sense of meaning and purpose, happiness and psychological well-being. Further, important practices like meditation and forgiveness have been found to improve several aspects of psychological health (Moreira-Almeida, Lotufo Neto, & Koenig, 2006). Most Ghanaians are known to have a strong belief in a supreme being or God which reflects in their response to events (Gyekye, 2003) which makes religion an important factor in understanding people reaction to adversities.

Social support has been identified by previous studies as one of the variables that enhance the well-being of persons with disabilities (Eliezer et al., 2011). Social support is considered as a resource that may serve as a buffer against stressful situations such as discrimination and violence and may also help improve one's psychological well-being (Itzick, Kagan, & Tal-Katz, 2018). Persons with disabilities are disadvantaged in their opportunities to enjoy social life (WHO & WB, 2011). This coupled with exposures to violence and discrimination may affect their health and well-being. It is, however, evident from the literature that favourable interactions with one's social environment are beneficial to one's psychological health and well-being (Tough, Siegrist, & Fekete, 2017).

There have been a number of studies that have examined the role of social support in the face of stressors (Afun, 2016; Asante, 2012; Atefoe, 2013). Many have viewed social support as a resource that serves as a buffer against stressful events (Schmitt et al., 2014). Violence and

discrimination are considered stressors which are often considered as having a negative association with psychological health (Schmitt et al., 2014). Social support has been suggested as a factor that strengthens the relationship between discrimination and psychological health.

One dominant hypothesis of the relationship between social support, violence and discrimination, and psychological health is that of social support hypothesis (Thoits, 2011). This hypothesis posits that persons with high levels of social support are less likely to feel the negative impact of stressors such as discrimination and violence on their psychological health. The hypothesis argues that those with high levels of social support are able to utilize this resource in a way that helps them to effectively cope with stressors. Schmitt et al. (2014) explored the literature on studies that examined the moderating effects of social support on mental health. They found that most of the studies, 73 out of 75 did not support the moderating hypothesis.

Another hypothesis that explains the relationship between violence and discrimination, social support and psychological health is the mediation hypothesis. This hypothesis holds that people who experience violence and discrimination may withdraw from their social contacts or perceive their social support networks as not being helpful. Consequently, their perceived level of social support reduces, which results in a negative effect on psychological health. In other words, social support is a mechanism through which violence and discrimination influence psychological health. Hatzenbuehler (2009) conducted a systematic review of mediators (including social support) between stigma and outcomes. The study found that in 4 out of 5 of the studies reviewed, social support mediated the relationship between stress and outcome.

2.3.3 Violence and Discrimination, and Psychological Health

Several studies have found associations between violence and discrimination and psychological health (Kelly et al., 2016; Schmitt et al., 2014; Stansfeld et al., 2017). For

example, a meta-analytic review by Schmitt et al. (2014) indicated that violence and discrimination have a negative impact on the well-being of people in all kinds of disadvantaged groups across a range of well-being measures. Schmitt et al., (2014) further found the association between discrimination and well-being to be significantly negative among both cross-sectional and longitudinal effect sizes, supporting the hypothesis that discrimination has a causal relationship with well-being. Stansfeld et al., (2017) found the experience of violence to be a causal factor in a number of emotional disorders associations

Kassah et al. (2013) found a relationship between different forms of abuse and psychological health among disabled children in Ghana. In a similar study among women with disabilities in Ghana, Kassah et al. (2014) found that participants who had experienced different forms of abuse such as social, physical and sexual violence expressed feelings of sadness, exhaustion, hopelessness, anger, fright and worthlessness. Another study by Opoku et al. (2016), also found psychological trauma as one of the consequences of sexual violence among women with disabilities in Ghana.

2.3.4 Attitudes and perceptions of Ghanaians about Disability

Tijm, Cornielje and Edusei (2011), in a qualitative study conducted in the Kumasi metropolis, wanted to understand what goes into the daily lives of individuals with physical disabilities and to also assess their needs. It was a cross-sectional qualitative study. The researchers found that participants had challenges with access to toilets, public buildings, transports. They also identified that generally, the participants struggled to cater for themselves. They also found discrimination as one of the challenges facing persons with disability in their everyday life. The study though done on a small sample size still gives us insight into what persons with disabilities goes through in their daily lives. Nevertheless, the findings cannot be generalized due to the fact that it was done in an urban city of Ghana with few participants.

Anum (2011) explored four families with who had a child with disability about their experiences including challenges they face and how they manage to cope in living with a child who has a disability. The researcher adopted a semi-structured interview guide, informal conversations, participant observations and narrative analysis for the exploration. The researcher found that families experience stigma, pressure on family finances and family relationships, and lack of institutional support. Anum (2011), concluded that the stigma the families faced were mostly due to lack of knowledge on the part of most Ghanaians on disability.

Naami, Hayashi and Liese (2012) conducted a study that sought to understand unemployment among women with physical disabilities in Tamale and issues associated with it. A qualitative approach through in-depth interviews for ten women with disability and two focus group discussions with 14 stakeholders. They found that employment was high among women with disability in Tamale and most of the women were not aware of the opportunities that were available to them. The researchers also observed that unemployment among women with physical disabilities was also associated with exclusion from education and funding as well as attitudinal issues and lack of funding opportunities. The study also pointed out that most government officials lacked knowledge about disability issues which reflect in their attitudes towards persons with disability. The study also identified that most participants felt that Ghanaian perceived persons with disability as incapable or doubted their abilities fit into or do most jobs. The study found that due to most Ghanaians superstitious beliefs, especially about the causes and reasons for disability, attitudes towards them are mostly negative. The study suggests that as much as the perceptions about disability is negative, some Ghanaians are very sympathetic towards them. This study just like most studies among persons with disability has limited generalizability, however, it gives useful information about the unemployment situation among persons with disability and especially women with disability.

Naami and Hayashi (2012) examined the attitudes of the students of the University of Ghana towards persons with disability. The researchers sampled 305 students from the University of Ghana and 393 students from a university in the north. They observed that 49% of their total respondent felt that persons with disabilities should share a classroom with persons without disabilities. When the responses of persons with disabilities were compared to that of persons without disability, the study found that persons with disabilities were more likely to agree with being in inclusive schools than persons without disabilities. 24% of respondents from the two universities responded that they would never buy from persons with disabilities nor even do business with them. This number is surprising since it is expected students at this level would know better about disability to agree to such a 'blatant prejudiced' statement. The researchers argued that most of their respondents supported the idea of integration and equal rights of individuals with disabilities. However, most of them felt uncomfortable relating to persons with disability. The findings of this study give a fair understanding of how some Ghanaian students in some universities view persons with disabilities. The study being a large survey is also generalizable to populations with similar characteristics. Nevertheless, the study was merely descriptive in nature and hence could not help us understand between respondents' characteristics and their responses.

In a qualitative study conducted by Dako-Gyeke and Asumang (2013) at Patang to explore the stigma and discrimination experienced by persons with mental illness in Ghana, the findings revealed that persons with mental illness were stigmatized and discriminated against in their interactions with their family members, friends, neighbours, employers and colleagues at work. The study reported that persons with mental illness were ridiculed at by members of the community and shunned by friends after they were diagnosed with mental illness. Also, most of the participants in the study reported that they were unemployed because they were unable to find or keep their jobs. This indicates that persons with mental illness are stigmatised and

discriminated against, it, however, did not explore the level of violence against them. The study was also limited to persons with mental illness and not persons with other disabilities.

In a similar study, Baffoe (2014) also used a qualitative approach to explore discrimination and marginalisation of people with disabilities. The study recruited and interviewed 120 participants across Ghana which comprised of 80 persons with disabilities, 20 parents or relatives of persons with disabilities, and 20 key informants comprising social workers, teachers and other public officials who provide services to persons with disability. This study included all persons with disability. The findings of this study supported the study by Dako-Gyeke and Asumang (2013) that persons with disability struggle to secure job and are shunned by people in their communities. The study also reports that sons with disabilities do not have equal access to quality education due to lack of support. This study sheds light on the discriminations faced by persons with disability in Ghana. However, the study is also silent on the violence faced by persons with disability.

Kassah, Kassah, and Agbota (2014) qualitatively examined the experiences of violence among children with disability. The researchers interviewed three key informants. The researchers categorised the forms of abuse as social, capital, physical and emotional. They found that children with disability faced social abuse in the form of isolation, neglect, restriction of movement and participation in social life. The capital abuse narrated by the informants has to do with the practice of killing disabled children. According to the study, the physical abuses experienced by disabled children were primarily physical assaults. The study argued that the experiences of emotional abuse have psychological consequences. Despite the interesting findings of this study, the sample size was too small for its findings to be generalized.

Opoku, Huyser, Mprah, Alupo, and Badu (2016) conducted another qualitative study to examine violence against women with disability in the Mampong Municipality of the Ashanti

region. The study recruited 41 women with intellectual, visual and hearing disabilities. It was found that most of the participants (28) had suffered sexual violence. The study identified factors such as poverty, rejection by families, isolation and unemployment as the cause. According to the study, the incidence of violence was highest among person with visual impairment followed by those with intellectual disability. It was also found that women with disability suffered consequences of violence such as unwanted pregnancies, divorce, outright rejection and psychological trauma. The researchers noted that barriers such as communication difficulties, poverty, and, lack of bond with families and friends limited their ability to report the abuse they experience. Despite this study's significant contribution to understanding violence among persons with disability in Ghana, the participants were only women and hence did not give us the picture of violence among men with disability in Ghana.

Opoku et al. (2017), sought to highlight the impact of family support on the lives of persons with disabilities in Ghana. They conveniently sampled 48 persons with physical disabilities from the northern region of Ghana. The findings of the study indicated that persons with disabilities do not get the required support from their families which hinders their social participation. They observed that families seemed uninterested in the well-being of persons with disabilities. This, according to the researchers reflected in parents leaving their wards with disabilities out of school whiles having their other siblings without disabilities in school. The study also found that because persons with disabilities have limited access to education, resulted in their inability to secure jobs.

Review of existing studies on violence and discrimination among persons with disabilities in confirms that barriers such as inaccessibility, stigmatization, discrimination, and violence are faced by persons with disability on a daily basis. Previous studies further indicate that due to most Ghanaians' superstitious beliefs, especially about the causes and reasons for disability, attitudes towards persons with disabilities are mostly negative. Despite their insightful contribution to the

literature on violence and discrimination among persons with disability in Ghana, most of the studies are qualitative in nature. These studies were also done on small sample sizes thereby limiting their generalisability. There is also not much information about the effect of the barriers faced by persons with disabilities on their psychological health.

2.4 Rationale for the Study

Studies reviewed so far indicate the presence of negative attitudes, discrimination and violence against persons with physical disabilities in Ghana. Most persons with disabilities in Ghana have been noted as poor, lacking access to education, lacking employment opportunities, excluded from society and labelled. Henceforth, there is the need to understand the types of discrimination and the forms of violence persons with disabilities are facing.

Discrimination against vulnerable groups such as persons with disabilities, either real or perceived, is considered to be significant stressors with a consequent negative effect on mental and physical health (Kelly, Kelly, & Macdonald, 2016). With this in mind, there was the need to study the impact of violence and discrimination on the psychological health and well-being which is one of the reasons for the current study.

The sheer presence of a disability does not lead to negative psychological outcomes but it is rather mostly triggered by external influences (Dunn, 2011). In most cases, there is the presence of fundamental attribution error where people focus mostly on internal characteristics, which is the impairment (inadequacies) of persons with disabilities rather outside of the person such as disability-based violence and discriminations. The current study, therefore, focused on situational factors that serve as barriers to persons with disability. This study will, therefore, add to the discussion on the links between violence and discrimination, and psychological health. Psychological health in this study is conceptualized as the presence or absence of psychological distress.

2.5 Hypothesis

1. Persons with disabilities who report higher levels of violence will have lower psychological well-being.

2.a. Persons with visible disabilities will significantly experience a higher levels of past-year violence and discrimination.

b. Persons with severe disabilities will significantly experience a higher levels of violence and discrimination

c. Persons with mental disabilities will significantly experience higher levels of past-year violence and discrimination as compared to persons with physical disabilities.

d. Persons with disabilities in rural areas will experience higher levels of past-year violence and discrimination as compared to persons with disabilities in peri-urban and urban areas.

3. a. Religiosity will moderate the relationship between violence and discrimination, and psychological health.

b. Gender will moderate the relationship between violence and discrimination, and psychological health.

4. Social support will mediate the relationship between violence and discrimination, and psychological health.

2.6 Hypothesized Model

In this model, education, type of disability, visibility and severity of a disability, and place of residence were hypothesised to be predictors of violence and discrimination. Violence and discrimination were also predicted to predict psychological health. Additionally, gender and religion were predicted to be moderators of the relationship between violence and

discrimination and psychological health, while social support was hypothesised as a mediator of the relationship between violence and discrimination and psychological health.

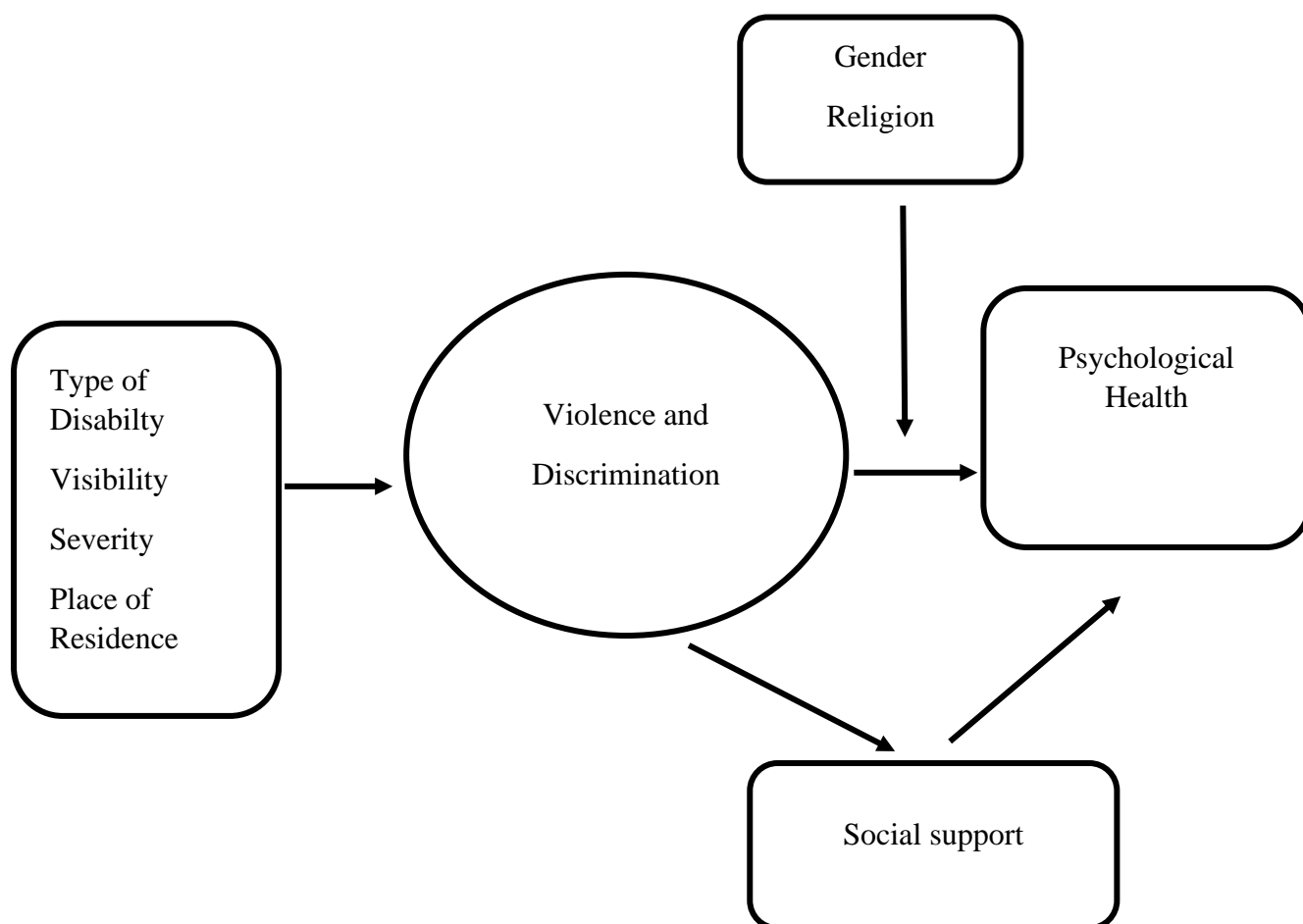


Figure 1: Hypothesized Model

2.7 Operational Definitions

Discrimination: When people are unfairly treated because they are perceived as different from others.

Violence: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood

of resulting in injury, death, psychological harm, maldevelopment or deprivation” (WHO, 2002)

Impairment: Problems in body function or structure such as a significant deviation or loss.

Activity limitations: These are difficulties in executing activities. For example, walking or eating

Participation restrictions: Problems with involvement in any area of life. For example, facing discrimination in employment or transportation.

A Person/People with disability: An individual who has difficulty in one or more of the following domains; impairment, activity limitation, and participation restrictions.

Psychological health in this study is conceptualized as the presence or absence of psychological distress.

Rural community: A community with a population fewer than 5000 inhabitants can be said to be a rural settlement (Ghana Statistical Service, 2012).

Urban community: A community with a population over 5000 can be said to be an urban community.

Peri-urban: Based on Rambaud (1973) suggestion that a peri-urban area is proximate to an urban area but with a large population than a rural area and has some level of both ‘urbaness’ and ‘ruralness’ as part of its characteristics- agricultural lands and commercial areas with a population dynamic close to the urban areas (Rambaud, 1973).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter provides information on the research methodology used in examining violence and discrimination experienced by persons with disabilities and its effects on their psychological health. This consist of It includes the population/sample, sampling technique, research design, measures, instruments as well as the procedures involved in the data collection process.

3.2 Research Setting and Population

The study was conducted in the Greater Accra and the Brong Ahafo Regions of Ghana. The target population of this study were persons who have lived with any form of disability for over a year. The number of persons with disability stood at 737,743, which represented three per cent of the Ghanaian population in 2010 (GSS, 2014). According to the GSS report on disability, persons with disability in the Greater Accra region represent 14.1% of the population of persons with disability in Ghana with most of them in urban areas (GSS, 2014). Persons with disability in the Brong Ahafo represent 7.3% of the Ghanaian population with a disability with most of them in rural areas (GSS, 2014).

3.3 Sample and sampling technique

The study was conducted using 200 persons with various forms of disability. The research sample size was generated by using G*Power 3.1.9.2 (Faul, Erdfelder & Buchner, 2007). To generate the sample required for the study, a priori power analysis based on Cohen's (1988; 1992) acceptable power of 0.95, an alpha of 0.05 and a medium effect size of 0.15 was conducted. The analysis required sample size, given the aforementioned power, alpha and medium to be 138. This meant that a sample size of 200 was enough for the proposed analysis.

Purposive and convenience sampling strategies were adopted in recruiting participants. Snowball or chain referral sampling methods was also used. Purposive sampling was used mainly because the study targeted persons with obvious disabilities or persons who had been diagnosed with a disability and met the inclusion criteria and also to help the researcher recruit from diverse backgrounds including gender, religion, socio-economic backgrounds; as well as across rural and urban settings. Similarly, convenience sampling was adopted to sample persons with disabilities who were available and willing to participate in the research. Snowball or chain referral was also used in order to help reach more target population as quickly as possible in the communities.

Design

A Cross-sectional survey was adopted for this study. This design was chosen because the current study sought to quantify the forms of violence and discrimination among people with disability in Ghana in a snapshot.

Inclusion Criteria

Persons who have lived with any form of disability for over a year between the ages of 18 - 65 years of age.

Exclusion Criteria:

- Persons with disabilities who are younger than 18 years of age.
- Persons with disabilities who were demented and persons with disability who cannot comprehend the study material or provide consent were excluded.

Instruments

A simple structured self-report questionnaire was used to gather the data for the current study.

Details are provided below:

Demographics:

The following demographic data about participants was collected: age, gender, religious affiliation and level of education.

2. Physical and mental disabilities

There is no universally accepted measure of disability (Mitchell, Ciemneck, CyBulski & Markesich, 2006), but this study adopted a set of questions typically used by other researchers to assess disability (Dammeyer & Chapman, 2018). In this section, participants were asked a direct question “Do you have a long-term physical health problem or disability” and/or “one or more mental disorders”. The response options were yes and no. Participants will then be asked to categorise their most serious physical and/or mental disability.

The study also measured the severity and visibility of disability. In the questionnaire, participants were asked if their main physical and/or mental disability is “minor or major”. They were asked: “Would a stranger recognize within five minutes that you have a disability/health problem/mental disorder?” The response categories for the latter were coded by this study as “always” and “sometimes/never”.

3. Violence and Discrimination

To measure violence and discrimination, questions from a similar study was adopted (Dammeyer & Chapman, 2018). For violence, separate forms of violence in the past 12 months, including physical violence, sexual violence, and non-physical violence were measured. For non-physical violence, they were asked: “In the past year, has someone: (1) Threatened you with violence (2) Humiliated, degraded or ridiculed you, or constantly criticized you; (3) Prevented you from accessing your money or bank account, blocked your bank card, or forced you to pay a sum of money or act as guarantor?”

For physical violence, the following questions were asked: “In the past year, has someone: (1) Shaken you, pushed you or pulled your hair; (2) Hit or kicked you?” The study will refer to (1) and (2) as “minor” and “major” physical violence respectively.

For sexual violence, participants were asked: “In the past year, has someone forced you to: (1) Kiss or hug; (2) Have sexual intercourse or engage in other sexual acts?” The study refers to (1) as “minor sexual violence” and (2) as “major sexual violence”.

In the survey, the following definition of discrimination was provided: “Discrimination occurs when people are unfairly treated because they are perceived as different from others.” In the questionnaire, participants were asked: “Do you feel that you are discriminated against because of your disability?”

The response option for all the questions measuring violence and discrimination is a “Yes” or “No”.

Social Support

The Multidimensional Scale of perceived Social support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988) was used to measure social support. It is a 12-item self-report measure that assesses three dimensions of social support (family, friends and significant other). A sample question is “I can talk about my problems with my family”. The response option is a 7-point Likert (1-7) scale that ranges from very strongly disagree to very strongly agree. The score for each domain or a subscale of a participant will be computed by adding up the ratings of each item of each support scale and dividing the total by 4. For the global score, ratings for all items on the scale are summed up and the resulting total is divided by 12. Zimet et al. reported a reliability coefficient α of .88 for MSPSS.

The Santa Clara Strength of Religious Faith Questionnaire

Santa Clara Strength of Religious Faith Questionnaire (Plante & Boccaccini, 1997) was used to measure religiosity. A sample item is “I look to my faith as providing meaning and purpose in my life”. It is a 10-item questionnaire on a 4-point Likert scale which ranges from 1 (strong disagreement) to 5 (strong agreement). The composite score is gotten by summing up all the responses with a minimum score of 10 and a maximum score of 40. The scale has been found to be internally consistent with a Cronbach alpha coefficient of between 0.94 and 0.97 (Plante & Boccaccini, 1997; Plante, 2010). The total can be derived by summing up all the responses with a minimum score of 10 and a maximum score of 40. Higher scores represent a higher level of religiosity while lower scores reflect a lower level of religiosity. In this study, the Santa Clara strength of religious faith inventory had a Cronbach alpha of 0.93.

Brief Symptoms Inventory (BSI 18) (Psychological health)

Psychological health was measured using Brief symptoms inventory 18 (BSI 18) (Derogatis, 2001). This is a short version of the Brief symptoms inventory contains the three six-item scales somatization, depression, and anxiety as well as the Global Severity Index (GSI). It was developed to help gather self-reported data to measure psychological distress and psychiatric disorders both in the medical and community populations. The BSI is a paper and pencil administered on a five-point Likert scale. The scale lists 18 problems people sometimes have and asks them to rate it base on their past 7 days including their experience on the day. An example of the symptoms on the scale is “Feeling no interest in things”. The response options range from 0, Not at all to 4, very often. High validity has been reported for BSI 18 which ranges between .89 to .94 (Asner-Self, Schreiber, & Marotta, 2006; Franke et a., 2017). The global score is obtained by adding all the options chosen by respondents.

Procedure

A pilot study was conducted to test the reliability of the measure for the study. Participants of the pilot study were conveniently recruited. Participants were recruited from urban, peri-urban and rural areas of two administrative regions in Ghana. They were contacted at homes, religious and other public spaces. The researcher introduced the study to them. Those who agreed to take part were given detailed information about the participation and objectives of the study. People who agreed to participate in the study gave written or oral informed consent as appropriate. Participants were made aware beforehand that participation was purely voluntary. Participants were also informed about their freedom to withdraw from the study if they so desire to discontinue the process even after they had given their initial consent. Additionally, participants were assured of confidentiality and anonymity. Questionnaires were administered individually to the participants by the researcher and two research assistants who moved around the various communities. Assistance was given to participants who may not be able to read and/or write. Surveys that were completed were concurrently prepared for data analyses. Raw data was handed over to the researcher as soon as they were collected, and was stored in a locked cabinet accessible only to the research team. After the collected data had been processed, electronic data was stored on the laptop of the principal investigator with a password to protect the data.

Ethical Considerations

In accordance with the APA (2002) Ethical Code, this study was guided by some ethical principles in the use of humans as participants for research. The ethical principles that were considered in this study include informed consent, freedom to withdraw, confidentiality and anonymity/privacy.

Ethical clearance was sought from the Ethics committee for humanities (ECH) of the University of Ghana. The questionnaire did not ask for any identifying information such as

name or address from the participants. The objective and the potential benefits of the study was explained to all participants. Participants were also informed about their freedom to withdraw from the study if they so desire to discontinue the process even after they have given their initial consent.

The participants were permitted to take the time they needed to complete the questions. They were allowed to complete the questionnaire at a later time or to stop entirely when they wish to. Participants were made aware that information gathered would be used only for the purpose for which it was collected. A written consent form will be shared. When appropriate, this information will be presented orally. After the collected data have been processed, electronic data will be stored in such a way as to protect the data. Participation was strictly voluntary as participants were not given any reward.

Data analysis

The IBM Statistical Package for Social Science (SPSS) version 23.0 was used to conduct the statistical analysis. Descriptive statistics made up of frequencies, percentages, means and standard deviations were carried to examine on the whole the descriptive features of the sample with regards to variables such as gender, religion, types of disabilities, educational level, age and place of residence. Hierarchical regression was used to test hypothesis 1, 2 and three. Chi-square test of independence was used to test hypothesis 4. SPSS process macro developed by Preacher and Hayes (2008) was used to test hypothesis five.

CHAPTER FOUR

RESULTS

4.0 Introduction

The results of the study are presented in three sections: The first is the demographic characteristics of the respondents, second is the preliminary analysis and the third section presents the hypothesis testing.

4.1 Demographic Data

200 persons with disability were sampled for the study. As presented in Table 1, out of the 200 persons with disability sampled, 105 representing 52.5 per cent were males. On participants educational level, the majority of the respondents with disability 72, representing 36 per cent had at least a secondary school education whiles 28 of the participants representing 14 per cent had no formal education. A look at respondent's employment status shows that a good number of persons with disability 25.5 per cent ($n = 51$) indicated that they were unemployed and looking for work, 21.5 per cent ($n = 43$) were employed full time, 12 per cent ($n = 24$) were unable to work. Majority of respondents were Christians, representing 73%. The respondents with disability had a mean age of 35.35 ($SD=11.07$).

Table 1: *Summary of Demographic Characteristics of Participants with disability in the study*

Demographics	With disability	
	N	%
Gender		
Male	105	52.5
Female	95	47.5
Educational Level		
No Formal Educ.	28	14
Primary Education	43	21.5
Secondary Education	72	36
Tertiary	56	28
Masters	1	0.5
Employment Status		
Employed Full Time	43	21.5
Employed Part-Time	6	3
Unemployed and Currently Looking for Work	51	25.5
Unemployed and Not Currently Looking for Work	8	4
Student	22	11
Retired	8	4
Self-Employed	38	19
Unable to Work	24	12
Religion		
Christian	146	73
Muslim	48	24
Traditional	1	0.5
No Rel. Affiliation	5	2.5
Place Of Residence		
Urban	74	37
Rural	81	40.5
Peri-Urban	45	22.5
	Mean	SD
Age	34.35	11.07

The above table summarises the distribution of participants according to specific types of mental and physical disorders. Persons with various mental disabilities made up 45.5 per cent (n=91) of the number of participants with disabilities, while those with physical disabilities

made up 54.5 per cent (n=109). Among persons with mental disabilities, people with mood disorders made up the highest number 33.9 per cent (n = 35) with people with autism spectrum disorders making up the least number 7.8 per cent (n = 8). For respondents with physical disabilities, those with motor and movement disorders, and those with vision loss were the highest with 31.9 per cent each (n = 31) while respondents with skin conditions made up the least number 4.1 per cent (n = 4).

Table 2: *Summary of respondents according to the specific type of disability.*

Disability type	Frequency	Percentage
Mental Disability	91	45.5
Mental Disabilities caused alcohol or substance use	16	15.5
schizophrenia and Psychosis	24	23.3
Mood Disorders (Depression and Bipolar)	35	33.9
Stress, Phobias, anxiety, OCD, PTSD, personality disorders	14	13.6
Autism Spectrum Disorders	8	7.8
Physical disability	109	54.5
Motor and Movement Disorder	31	31.9
Blindness and Vision Loss	31	31.9
Deafness and Impaired Hearing	21	21.6
Skin Condition	4	4.12
Allergies and Breathing Difficulties	5	5.2
Chronic Conditions and Progressive Diseases	11	11.3

As indicated in Table 2, 26% (n=29) of persons with physical disabilities and 61.2% (n = 60) of persons with mental disability reported past year experience of threat. People with mental disabilities were more likely to report all categories of violence than persons with physical disabilities. This is confirmed by the regression analysis which found that type of disability significantly predicted violence (see Table 8). Table 3 below summarises the comparisons between persons with physical disabilities and those with mental disabilities.

VIOLENCE AND DISCRIMINATION AMONG PERSONS WITH DISABILITY

Table 3: Frequency of self-reported past-year violence and discrimination with regard to type of Disability (Physical/mental)

Disability	Threatened physical yes % (n)	Humiliated yes % (n)	Financial yes % (n)	Physical minor yes % (n)	Physical major yes % (n)	Sexual Minor 1 yes % (n)	Sexual Minor 2 yes % (n)	Sexual major yes % (n)	Discrimination yes % (n)
Physical disability	26.6(30) ns	37.6(41) ns	32.1(35) *	25.7(28) ns	20.2(22)	11(12) *	22.9(26)	7.3(9)	68.8(70) **
Mental disability	61.2(60) **	51(50) **	36.7(36)	65.3(63) **	38.8(38) **	29.6(29) *	26.5(26) ns	22.4(22) **	72.4(63) **
Mental disability compared to physical disability	**	**	**	**	**	*	**	*	**

Note: Chi square statistics for comparisons with participants with “no disability”, *p < .05, **p < .01, ns = not significant

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With regard to specific type of mental disabilities, persons with alcohol or substance-induced mental disorders reported higher levels of being threatened 93.8% (n=15), financial violence 93.8% (n = 15), minor physical violence 93.8% (n = 15) and major physical violence 75% (12) than all other types of mental disabilities. Respondents with schizophrenia and psychosis reported the highest level of past year humiliation 54.2(n = 14) than all other mental disabilities. Persons with mood disorders recorded high past year levels of a minor (42.9%, n = 15) and major sexual violence (40%, n = 14) as compared to other mental disabilities.

With regard to a specific type of physical disabilities, persons with motor disabilities reported higher levels of threatened violence (41.7%, n = 14) than all other categories of physical violence. Those with blindness or loss of vision reported higher levels of humiliation than all other physical disabilities within the past one year. The findings further indicated that persons with chronic conditions reported higher levels of financial violence (45%, n = 5) and lower levels of all other forms of violence as compared to all other physical disabilities. Persons with deafness or hearing impairments recorded the highest number of reported sexual violence (n = 4, 18.2%) as compared to all forms of physical disabilities.

Among persons with disabilities, mental disabilities 72.4% (n = 71) recorded slightly higher levels of discrimination than physical disabilities 68.8(n = 75). Regarding specific mental types of disabilities, those with autism spectrum disorders reported the highest level of discrimination with 7 out of 8 respondents while those with mood disorders reported the lowest level (45.7%, n = 16). Findings also show that among people with physical disabilities, those with motor reported the highest-level while people with chronic disabilities reported the lowest levels.

Among place of residence, findings indicated that discrimination was highest among persons with disabilities who reside in rural areas as compared to those who reside peri-urban and urban. This was supported by results from Pearson's chi-square analysis, which indicated that

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the relationship was statistically significant $\chi^2(2, n = 200) = 7.27, p < .05, v = .20$. All forms of violence measured were highest among rural residents with the exception humiliation which and minor physical violence which were highest among peri-urban (44.4%, $n = 20$) and urban (45.9%, $n = 34$) residents respectively. As presented in Table 4, comparisons between places of residence on outcomes of forms of violence resulted in significant differences in all except threat and minor physical violence.

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Table 4: Frequency of self-reported past-year violence and discrimination with regard to the type of physical and mental disability

	Threatened physical yes % (n)	Humiliated yes % (n)	Financial yes % (n)	Physical minor yes % (n)	Physical major yes % (n)	Sexual Minor 1 yes % (n)	Sexual Minor 2 yes % (n)	Sexual major yes % (n)	Discrimination yes % (n)
Physical Disability (types)									
Motor (n=36)	15(41.7)	14(38.9)	11(30.6)	12(33.3)	11(30.6)	5(13.9)	10(27.8)	2(5.6)	28(77.8)
Vision (n=32)	8(25)	15(46.9)	10(31.2)	5(15.6)	4(12.5)	2(6.2)	5(15.6)	2(6.2)	20(62.5)
Hearing(n=22)	4(18.2)	7(31.8)	7(31.8)	7(31.8)	4(18.2)	4(18.2)	9(40.9)	4(18.2)	16(73)
Skin (n=4)	2(50)	2(50)	0(0)	1(25)	2(50)	1(25)	1(25)	1(25)	2(50)
Allergy (5)	1(20)	1(20)	2(40)	2(40)	1(20)	0(0)	1(20)	0(0)	3(60)
Chronic (11)	0(0)	2(18.2)	5(45.5)	1(9.1)	0(0)	0(0)	0(0)	0(0)	1(9.1)
Mental Disability(types)									
Alcohol /drugs (16)	15(93.8)	9(56.2)	15(93.8)	15(93.8)	12(75)	4(25)	6(37)	1(6.2)	12(75)
Schizo/psychosis(n=24)	20(83.3)	14(58.3)	13(54.2)	22(91.7)	15(62.5)	6(25)	5(20.8)	4(16.7)	20(83)
Mood (n=35)	11(31.4)	17(48.6)	4(11.4)	10(28.6)	2(5.7)	15(42.9)	8(22.9)	14(40)	16(45.7)
Stress(n=15)	9(60)	7(46.7)	2(13.3)	9(60)	2(13.3)	3(20)	4(26.7)	3(20)	8(53.3)
Autism(n=8)	5(62.5)	3(37.5)	2(25)	7(87.5)	7(87.5)	1(12.5)	3(37.5)	0(0)	7(87.5)
Residence									
Urban	36.5(27)	31.1(23)	28.4(21)	45.9(34)	25.7(19)	10.8(8)	13.5(10)	6.8(5)	58.1(43)
Peri-urban	40(18)	44.4(20)	20(9)	40(18)	24.4(11)	22.2(10)	22.2(10)	16(13)	62.2(28)
Rural	45.8(38)	40.6(41)	43.2(35)	42(34)	30.9(25)	28.9(13)	27.2(22)	24.4(11)	75.3(61)
chi square comparisons among places of residence	ns	*	*	ns	*	*	**	*	*

*p < .05, **p < .01, ns = not significant

4.2 Preliminary Analyses

The main continuous variables: social support, religiosity and brief symptoms inventory were checked for normality, using the skewness indices of -2 to +2 and kurtosis indices of -7 to +7 as described by (Field, 2013; Spiegel & Stephens, 2008). The means and standard deviation and Cronbach Alphas were also estimated (see Table 1). Normality analyses for skewness and kurtosis indicated that the data was fit for parametric tests.

Table 5: *Psychometric properties of the main study variables*

Measure	Number of items	M	SD	Alpha(α)	Skewness	Kurtosis
Social Support	12	53.80	12.82	.89	-0.33	-.95
Religiosity	10	39.78	8.05	.93	-0.65	-.28
Brief Symptoms Inventory	18	17.42	0.71	.93	0.58	-0.34

In order to examine the linear relationship among the underlying variables to be used in the regression analyses, a pairwise correlation was carried out using the Pearson correlation coefficient. There were relatively low correlations among predictor variables ($r < 0.6$); this suggested that there would be no multicollinearity among the predictors. Table 6 is a summary of the results of the correlations.

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Table 6: Correlation matrix of key study variables

Variable	1	2	3	4	5	6	7	8
1 Psychological Health	-							
2 Gender	-.01 ^{ns}	-						
3 Residence	.12 ^{ns}	.17 [*]	-					
4 Visibility of Disability	.01 ^{ns}	.004 ^{ns}	.02 ^{ns}	-				
5 Social support	-.68 ^{**}	.02 ^{ns}	-.08 ^{ns}	.10 ^{ns}	-			
6 Religiosity	-.48 ^{**}	.01 ^{ns}	-.03 ^{ns}	.14 ^{ns}	.46 ^{**}	-		
7 Violence and discrimination	-.56 ^{**}	-.06 ^{ns}	-.18 [*]	-.05 ^{ns}	.45 ^{**}	.23 ^{**}	-	
8 Form of disability	.57 ^{**}	.05 ^{ns}	.07 ^{ns}	.35 ^{**}	-.27 ^{**}	-.06	-.45 ^{**}	-

***Significant at .01 alpha level, *Significant at .05 alpha level, ns=not significant*

Hypothesis Testing

This sub-section focuses on the findings from the testing of the hypothesis.

Hypothesis One

1. Persons with disabilities who report higher levels of violence will have lower psychological well-being.

A series of hierarchical multiple regression was used to determine the effects of violence and discrimination on psychological health, after controlling for gender, education, residence, visibility and severity of a disability. Violence and discrimination, was computed by summing up all the items on violence and discrimination.

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Table 7.*Hierarchical multiple regression results predicting aspects of psychological health.*

	R ²	ΔR ²	B	Std. Error	β	t	p
Step 1 (control variables)	.08	.08					0.2
Age			-.07	.08	-.07	-.90	.38
Gender			-1.51	1.76	-.06	-.86	.39
Education			-.29	.83	-.25	-3.48	.001
Residence			1.20	1.12	.08	1.08	.28
Visibility			.33	1.25	.02	.26	.79
Severity			.07	1.66	.003	.04	.97
Step2(independent variable)	.34	.28					.001
Violence and Discrimination			.53	.48	-.58	-8.41	.001

Hierarchical linear regression was adopted to analyse the main hypothesis through a two-step approach to test the predictive strength of violence and discrimination on psychological health. At Step 1, the dependent variable (i.e. Psychological health), as well as the control variables (i.e. age, gender, education level, residence, visibility and severity), were entered into the model. At Step 2, the independent variables (violence and discrimination) were entered. The overall model at step 1 accounted for a significant amount of variance in psychological health, $R^2 = .08$, $F(6,193) = 2.64$, $p < .001$. Among the control variable education was the only factor found to be significant in explaining 29 % of the variance in psychological health ($\beta = -.29$, $p < .001$). At step two, there was a significant change in R^2 with the whole model explaining 34% of the variance. Violence and discrimination were found to be a negative predictor of psychological health ($\beta = .53$, $p < .001$), the result supported hypothesis 1 which predicted that violence and discrimination will negatively predict psychological health.

Hypothesis Two

a. Persons with visible disabilities will significantly experience a higher level of past-year violence and discrimination.

b. Persons with severe disabilities will significantly experience a higher level of violence and discrimination

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c. Persons with mental disabilities will significantly experience higher levels of past-year violence and discrimination as compared to persons with physical disabilities.

d. Persons with disabilities in rural areas will experience higher levels of past-year violence and discrimination as compared to persons with disabilities in peri-urban and urban areas.

Hierarchical regression was used to examine the predictive power of form (physical or mental), visibility and severity of a disability, and place of residence on past year experience of violence among persons with disability. Violence was computed by adding all the items on violence to form a composite score. At Step 1, the dependent variable (i.e. total violence), as well as the control variables (i.e. age, employment status, education level), were entered into the model. At Step 2, the independent variables (i.e. type, visibility, the severity of a disability, and place of residence) were entered into the model.

As can be seen from Table 8, the model at Step 1 was statistically significant, accounting for 11% of the variance in past year experience of violence among persons with disability $R^2 = .11$, $F(3,196) = 7.95$, $p < .001$. Education ($\beta = .21$, $p < .01$) was a significant predictor of violence and discrimination among persons with disability in the model in step 1. Step 2 was also statistically significant explaining an additional variance of 28% in past year experience of violence ($\Delta R^2 = .28$, $p < .01$). After controlling for age, gender and education, the form of disability, was found to be the highest significant predictor of violence among persons with disabilities, uniquely accounting for 56% of the variance ($\beta = .56$, $p < .001$). This finding supported hypothesis 2c which stated that mental disability will significantly predict higher past-year violence and discrimination than physical disability. Visibility of disability was also significant in the model at step two ($\beta = .33$, $p < .05$), which supports hypothesis 2a. Rural residence ($\beta = .11$, $p = .02$) was also a significant predictor of violence and discrimination. This supports hypothesis 2d. However, hypothesis 2b ($\beta = .004$, $p = .95$) was not statistically significant.

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Table 8: Hierarchical multiple regression results predicting aspects of violence and discrimination among persons with physical and mental disabilities.

	R ²	ΔR ²	B	Std. Error	β	t	p
Step 1 (control variables)	.11	.11					.00
Age			-.02	.01	.15	2.17	.06
Employment			-.11	.06	.15	-1.89	.60
Education			.35	.13	.21	2.67	.01
Step2(independent variables)	.39	.28					
Visibility			.33	.16	-.13	2.10	.04
Severity			.02	.20	.004	.06	.95
Place of residence			.15	.13	.11	-1.11	.02
Form of disability (mental)			-1.90	.21	.56	-9.16	.001

Hypothesis three

The hierarchical multiple regression was also used to test hypothesis 4 that religiosity and gender will moderate the relationship between discrimination and violence, and psychological health (see Table 9).

At Step 1, the dependent variable (Psychological Health) and the independent variable (i.e. violence and discrimination) were entered into the model. At Step 2, the moderator variables (religion and gender) were each entered into the model. Before the analysis, the variables excluding gender which was dummy coded were centred and an interaction term between violence, discrimination and each of the moderator variables were created at step 3 to reduce multi-collinearity and enhance the interpretability of the interaction terms, (Aiken & West, 1991). The analyses were done separately for each of the two moderators in this study (i.e. religion and gender). In order to check the moderation effect of a variable in the relationship

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between an independent variable and a dependent variable, the nature of this relationship must change once the moderator variable changes (Aiken & West, 1991). The addition of the interaction to the model should lead to a significant explanation of the outcome variance better than without.

To test for moderation effects of religiosity and gender on the relationship between violence and discrimination and psychological health, hierarchical regression analysis using SPSS was conducted. In each equation and in the first step, the dependent variable psychological health was regressed on the independent variables, violence and discrimination. In the second step, the moderator variables were introduced and the interaction term or product between violence and discrimination, and the moderator was entered into the analysis at the third stage.

Table 9: Hierarchical multiple regression results predicting aspects of psychological health.

Variable	R ²	ΔR ²	B	SE	β
Step 1: IVs	.31	.31***			
Violence and discrimination			-.58	.47	-.58**
Step 2: MVs					
Religiosity	.43	.13***	-3.35	.65	-.37**
Gender	.31	.002***	1.04	1.39	.04 ^{ns}
Step 3: Product term					
Violence/discrimination*Reli	.45	.02***	-.14	.05	-.17**
Violence/discrimination*Gender	.34	.04***	-4.42	1.36	-.27**

* $p < .05$, ** $p < .01$, *** $p < .001$, SS=Social Support, Rels= Resilience, P=Personality, Reli=Religiosity

As presented in the table above, in all equations, the variables in the first step accounted for a significant amount of variance ($R^2 = .31$, $F(1, 198) = 88.01$, $p < .001$).

The moderation effect of religiosity on the relationship between violence and discrimination, and psychological health was also tested at step two. The model was significant and explained 46% of the variance ($R^2 = .43$, $F(2, 197) = 76.59$, $p < .001$; $\Delta R^2 = .13$, $p < .001$), Religiosity

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was also uniquely significant ($\beta = .37, p < .01$). The introduction of the interaction term to the model, the overall model was significant ($R^2 = .44, F(3, 196) = 53.91, p < .001; \Delta R^2 = .02, p < .01$), indicating that religiosity moderated the effect of violence and discrimination on psychological health. Hypothesis 4c was therefore supported. Hypothesis 4a was therefore supported. To better understand this results a graphic representation of the moderation analyses was plotted (Figure 2).

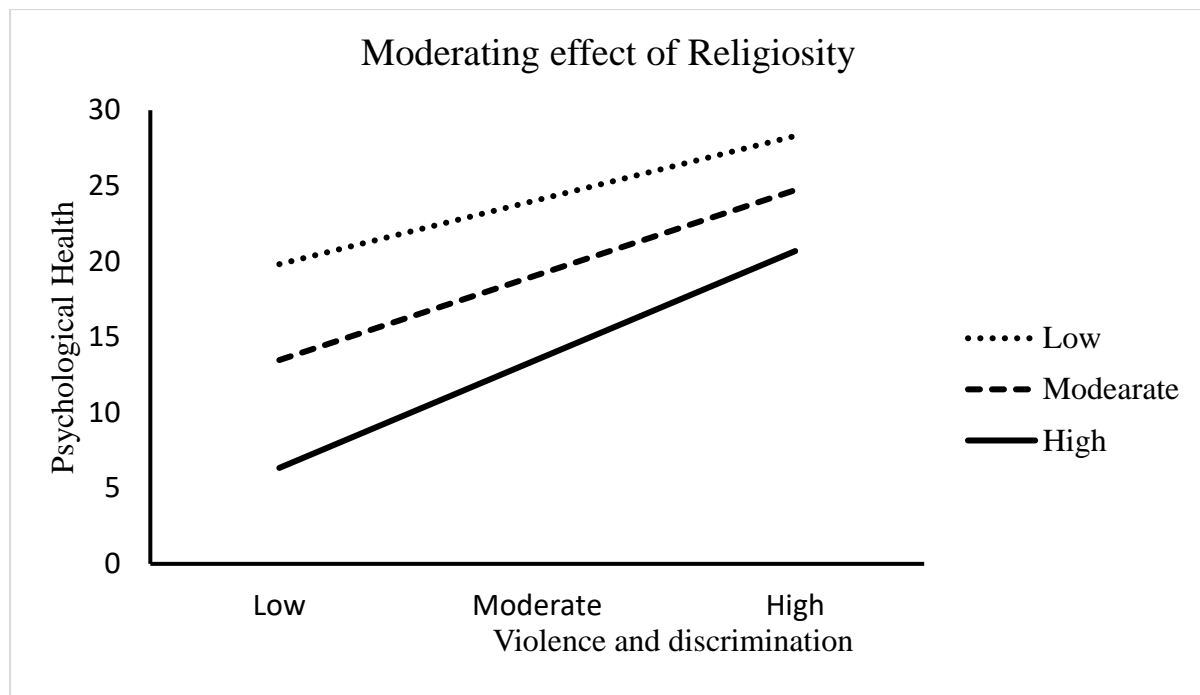


Figure 2: Interaction plot for the moderation effect of religiosity.

It can be observed from Figure 2 that there is a negative relationship between violence and discrimination and psychological health. The interaction term suggests that for the same values of violence and discrimination, people with low religiosity tend to have higher scores on psychological health (BSI) than people with moderate and high religiosity respectively for the same experience of violence. This indicated that religiosity buffered the association between violence and discrimination, and psychological Health.

When the gender was introduced to the model at step two, the overall model was significant and accounted for ($R^2 = .31, F(2, 197) = 44.19, p < .001; \Delta R^2 = .002, p < .001$). However,

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gender was not a unique predictor of psychological health in this model. The interaction term between violence and discrimination and gender was introduced at step three. The model was significant with the interaction term also being uniquely significant ($\beta = -.17, p < .01$). Gender, therefore, moderated the relationship between violence and discrimination, and psychological health. These findings support hypothesis 4b. To better understand this results a graphic representation of the moderation analyses was plotted (Figure 3).



Figure 3: Interaction plot for the moderation effect of gender

An examination of Figure (3) indicates that an increase in violence causes an increase in Psychological Health (BSI). The slope that predicts the change in psychological health according to the level of violence differs significantly between male and female gender. However, this association is less pronounced among males so for high levels of violence and discrimination, females showed a higher association for violence and discrimination, and psychological health.

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Hypothesis four

Social support will mediate the relationship between violence and discrimination, and psychological health.

To test for the mediation effects of social support on the relationship between violence and discrimination, and psychological health, SPSS process macro developed by Preacher and Hayes (2008) was used for the analysis. Mediation analysis was conducted using the bootstrapping method with 5000 bootstraps resamples and bias-corrected confidence estimates (MacKinnon, Lockwood, & Williams, 2004; Preacher & Hayes, 2004).

In Step 1 of the mediation model, the regression of violence and discrimination on psychological health, without the effect of the mediator, was significant, $b = -3.33$, $t(198) = -9.38$, $p < .001$. Step 2 showed that the regression of violence and discrimination on the mediator, social support, was also significant, $b = 2.96$, $t(198) = 7.03$, $p < .001$. Step 3 of the mediation process showed that the mediator (social support), controlling for violence and discrimination, was significant, $b = -.49$, $t(197) = -.97$, $p < .001$. Step 4 of the analyses revealed that controlling for the mediator (social support), violence and discrimination scores were a significant predictor of psychological health, $b = -1.88$, $t(197) = -5.81 < .001$.

Table 10: *Mediation Effects of social support for persons with disability on the Relationship between violence and discrimination, and Psychological health, N = 200*

Effect	<i>b</i>	95% CI	
		Lower	Upper
Total	-3.33	-4.03	-2.63
Direct	-1.88	-2.52	-1.24
Indirect (Mediation)	-1.44	-1.90	-1.02

As presented in Table 10, the indirect effect from the process analysis indicated that social support partially mediated the relationship between violence and discrimination and, psychological health as the indirect effect of X on Y was significantly greater than zero. The

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findings suggest that as persons with disability experience violence, their perception of social support reduces which in turn partially increases psychological health.

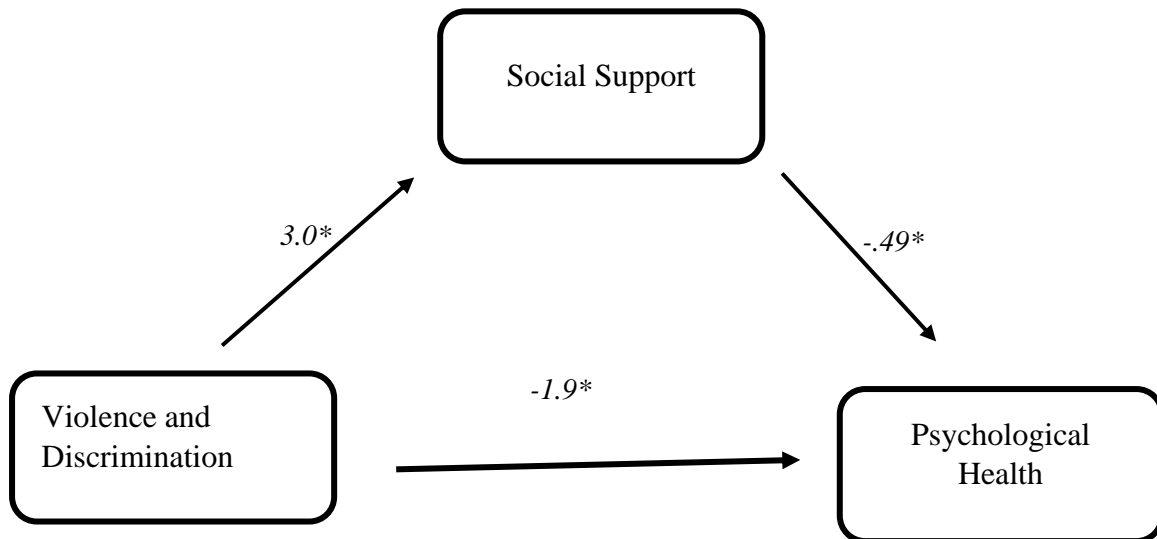


Figure 4: Mediating role of social support

Hypothesis five

There will be a significant difference between males and females in the experience of forms of violence and discrimination.

Chi-square test for independence was used to compare differences for outcomes (types of violence and discrimination) on the basis of gender. Chi-square test for independence (with Yates Continuity Correction) indicated no significant relationship between gender and physical threat, $\chi^2(1, n = 200) = .71, p = .40, phi = .07$ and humiliation $\chi^2(1, n = 200) = .56, p = .46, phi = -.06$ among persons with disability. However, as reported in Table 11, the chi-square test for independence was significant for experience of financial violence, minor physical violence, major physical violence and all forms of sexual violence. The findings show that males with physical disability are significantly more likely to experience financial minor and physical forms of violence while females are significantly more likely to experience all forms of sexual violence and humiliation than males. For example, 26% ($n = 25$) of women with physical

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disability reported experiencing at least a major sexual violence within the past year compared with 3.8% (4) men with disabilities. Chi-square comparisons of males and females are summarised in Table 11.

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Table 11: Frequency of self-reported past-year violence and discrimination with regard to gender among participants with physical and mental disability

	Threatened physical yes % (n)	Humiliated yes % (n)	Financial yes % (n)	Physical minor yes % (n)	Physical major yes % (n)	Sexual Minor 1 yes % (n)	Sexual Minor 2 yes % (n)	Sexual major yes % (n)	Discrimination yes % (n)
Male	44.8(47)	39(41)	39(41)	53.3(60)	40(42)	4.8(5)	8.6(9)	3.8(4)	69.5(73)
Females	38.9(36)	45.3(43)	25.3(24)	31.6(30)	13.7(13)	35.8(34)	42.1(40)	26.3(25)	69.5(66)
Males compared to females	ns	ns	*	*	**	**	**	**	ns

Note: Chi square statistics comparisons, *p < .05, **p < .01, ns = not significant

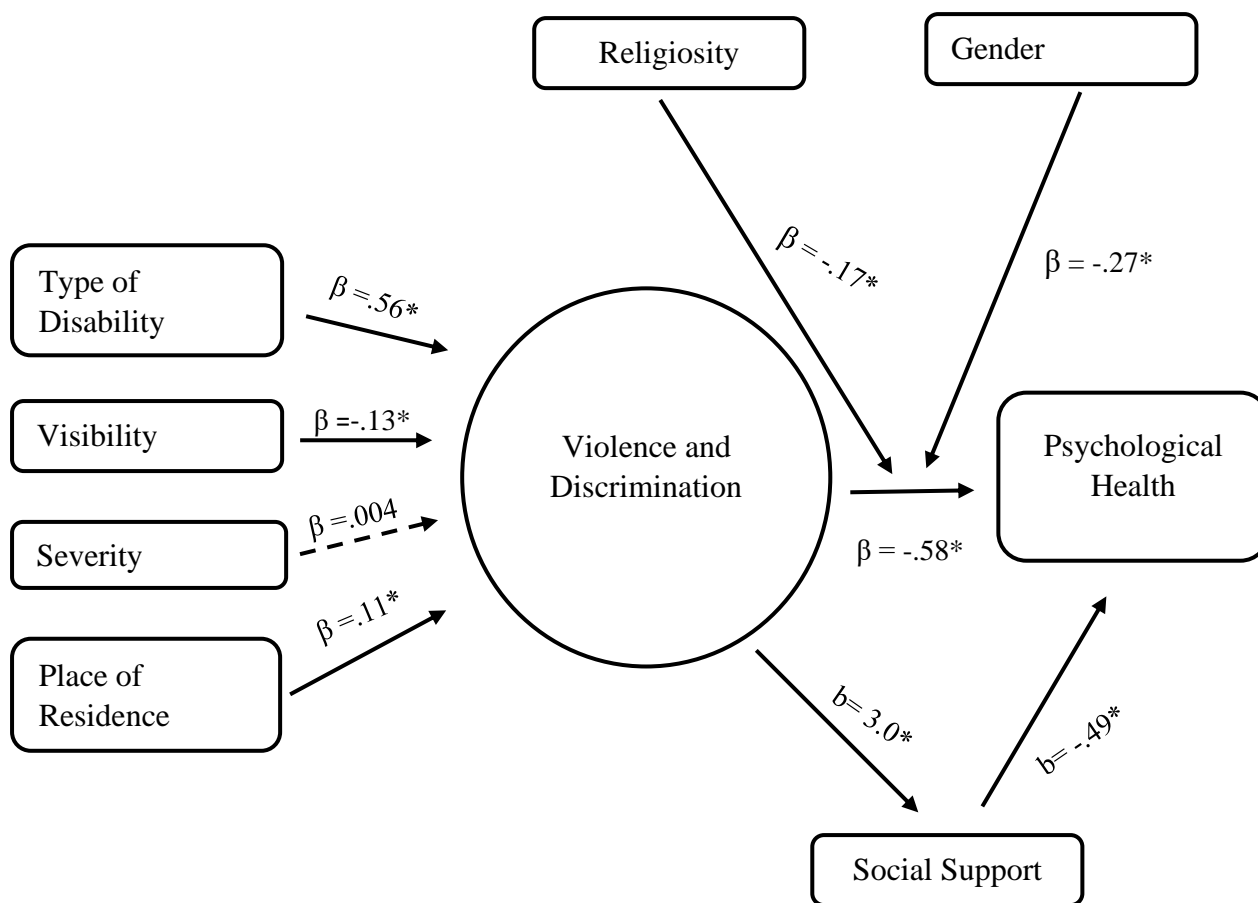


Figure 5. Observed model

Summary of results

The aim of the current study was to examine violence and discrimination experienced by persons with disabilities and how it affects their psychological health.

Analysis of the descriptive statistics reveals that all forms of violence and discrimination were high among persons with disabilities. There were also significant differences in experiences of violence and discrimination between persons with physical disabilities and those with mental disabilities.

The study found that after controlling for demographics such as level of education, age, and gender; the form of disability and visibility of disability were found to be significant predictors

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of violence and discrimination. The study found a significant difference between men and women in their experiences of violence with men experiencing more physical violence while women experienced more forms of sexual violence.

Violence and discrimination were found to be a statistically significant predictor of psychological health after controlling for gender, education, residence, visibility and severity of the disability. Among the control variables, only education was found to be a significant predictor of psychological health. The analysis further revealed that factors such as religiosity and gender moderated the relationship between violence and discrimination, and psychological health. Social support was also found to partially mediate the relationship between violence and discrimination, and psychological health.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter reviews and interprets the findings of the present study which mainly sought to examine violence and discrimination experienced by persons with disabilities and its effects on their psychological health. Specifically, the study examined the impact of experiences of violence and discrimination among people with disabilities on their psychological health. Additionally, the current study investigated factors that can influence the relationship between violence and discrimination, and psychological health. Finally, factors that can predict violence and discrimination among persons with disabilities. The findings of the study are discussed with reference to other related empirical studies and theories reviewed. Limitations of the study, as well as implications and conclusion, would also form part of this chapter.

5.2 Violence and discrimination and psychological health

Analysis of the main hypothesis of the current study found violence and discrimination to be a statistically significant predictor of psychological health. The regression analysis indicated that violence and discrimination explain 34% of the variance in psychological health. The findings are consistent with several studies that have found an association between violence and discrimination, and psychological health (Kelly et al., 2016; Schmitt et al., 2014; Stansfeld et al., 2017). For example, meta-analytic review by Schmitt et al. (2014) indicated that violence and discrimination have a negative impact on the well-being of people in all kinds of disadvantaged groups across a range of well-being measures. Schmitt et al. (2014) further found the association between discrimination and well-being to be significantly negative among both cross-sectional and longitudinal effect sizes, supporting the hypothesis that discrimination has a causal relationship with well-being.

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Similarly, a previous study in Ghana by Kassah et al. (2013) found a relationship between different forms of abuse and psychological health among disabled children in Ghana. Another study by Opoku et al. (2016), also found psychological trauma as one of the consequences of sexual violence among women with disabilities in Ghana. These findings suggest that experiences of poor treatment (including violence and discrimination) and having worse outcomes (i.e. being vulnerable and disadvantaged) than others impacts negatively on psychological health.

5.3 Moderators of the relationship between violence and discrimination and psychological health.

Given the findings on the effect of violence and discrimination on psychological health, it was pertinent to examine factors that can influence this relationship. First, the moderation effect of religiosity and violence were examined, followed by the mediation effect of social support.

Results of moderating analysis for the effect of religiosity showed that the interaction between violence and discrimination, and religiosity produced a significant model which suggests that religiosity moderates the impact of violence and discrimination experience on psychological health. Moreover, it showed that with the same or similar experience of violence and discrimination persons with disabilities who had low religiosity will score higher on psychological health than those with moderate to high religiosity. Additionally, the graphical representation of data clarified these findings showing that for the same levels of experienced violence and discrimination, those with low religiosity tend to score higher on psychological health than those with moderate religiosity. Therefore, findings of the present study demonstrated that religiosity buffered the relationship between violence and discrimination, and psychological health.

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The findings are in line with previous research that religiosity has a positive association with mental health (Marini & Graf, 2011; Weber & Pargament, 2014), and has a moderating effect between stressors and psychological health. This finding may be due to the fact that there are several positive emotions that may be associated with well-being like gratitude, reverence, hope and awe which are significant aspects of religious teachings and experiences (Rosmarin, Krumrei, & Andersson, 2009). Also, important religious practices like meditation and forgiveness have been found to improve several aspects of psychological health (Moreira-Almeida et al., 2006). The finding is very relevant since religiosity has been found to be high among Ghanaians (Gyekye, 2003). Similarly, Gyamfi, Hegadoren, and Park (2018) found that in responding to forms of discrimination, most Ghanaians resort to prayers and reading of the bible as a form of coping.

Analysis of the moderating effect of gender showed that the interaction between violence and discrimination and gender produced a significant model which suggests that gender moderates the impact of violence and discrimination on psychological health. Furthermore, it showed that there was an obvious association between violence and discrimination, and psychological health for female than males. The graphical representation of data showed females scored higher on psychological health for the same level of violence as compared to males. These findings, therefore, demonstrated that gender serves as a moderator of the effect of violence and discrimination on psychological health.

The results are consistent with the World Health Organization (2015)'s finding that women and girls are at an increased risk of experiencing "double discrimination", which includes gender-based violence, abuse and marginalization. The findings are also in line with a study by Foster et al. (2004) which found that females who are exposed to violence reported more depressive and anxiety symptoms than males. The findings, however, contradict

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a study by Hanson et al. (2008) which found no systematic gender differences in the impact of exposure to violence on post-traumatic stress disorder.

5.4 Social support as a mediator between violence and discrimination and psychological health.

The mediation effect of social support on the relationship between violence and discrimination and social support was analysed. The findings suggested that as persons with disability experience violence, their perception of social support reduces which in turn partially affects psychological health. This may be as a result of the fact that, when persons with disabilities experience violence and discrimination, their perception of social support reduces which in turn leads to an increase in psychological distress. These findings are consistent with previous findings (Elliot & Doane, 2015; Kondrat et al., 2018). The results, however, contradict Johnstone et al.'s (2015) study which found that social support not to be a mediator of stigma and mental health. The findings imply that as persons with disability experience violence, their perception of social support reduces which in turn partially increases psychological health. The findings are also in agreement with the stress process model which argues that protective resources may themselves be affected by stressors (McLeod, 2012).

Predictors of violence and discriminations among persons with disability

The findings of the current study suggest that violence and discrimination is very high among persons with all forms of disability. This finding is consistent with Kavanagh et al.'s (2013) observation that persons with disabilities are more likely to experience social exclusion, unemployment and abuse and other forms of discrimination. Similarly, a meta-analysis by Hughes et al (2012) found violence to be a serious problem faced by persons with disability as they are at an increased risk of violence as compared to persons without disabilities. The findings also support a qualitative study by Kassah et al. (2014), which found that persons with

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disabilities experience several forms of violence including isolation, neglect and restriction of movement. Furthermore, these findings are in line with the stress process model which argues that people who are vulnerable and disadvantaged are relatively more prone to stressors. These findings could be as a result of some Ghanaians perceptions about disability which has been observed to be ambivalent (Naami & Hayashi, 2012). Naami and Hiyashi (2012) also found in their study that people feel uncomfortable interacting with persons with disabilities, with a substantive minority holding strong prejudices about persons with disability. These perceptions can be partly explained by the social identity theory in the sense that persons with disability would be seen by persons without disability as different hence may act differently towards them. These findings suggest that urgent steps must be taken to help protect the basic human right of persons with disabilities to who by virtue of their vulnerability are at an increased risk of violence.

The study further found that levels of all kinds of violence among people with mental disability to be significantly higher than those with physical disabilities. Regression analysis also indicated the form of violence that is, either physical or violence significantly predicted violence among persons with disability. This is consistent with other researches that have found past-year violence to be highest among persons with mental disabilities as compared to persons with physical disabilities (Dammeyer & Chapman, 2018; Hughes et al., 2012). The findings also corroborate the qualitative findings by Dako-Gyekye and Asumang (2013) at Patang hospital which found that persons with mental disabilities experience different forms of stigma and discrimination in their interactions with relatives, friends, employers and co-workers. The study found that persons with mental disabilities were avoided by friends after they were diagnosed with mental disability. According to the study, participants indicated that they were not able to find or maintain their jobs. According to Mullen (2006), most mental disabilities

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are inherent with interpersonal difficulties which therefore predisposes persons with these mental disabilities to violence and discrimination.

The study's findings with regards to gender revealed that physical and financial violence were relatively common among men with disabilities than women past-year whereas sexual violence and humiliation was common among females as compared to males. This finding supports a study by Dammeyer and Chapman (2018) which found significant differences in reporting past-year physical and sexual violence among persons with disabilities, with men reporting higher physical violence and women reporting higher levels of sexual violence. Kassah et al. (2014) also found that sexual violence is common among women with disabilities in Ghana. The findings also support a qualitative study by Opoku et al. (2016) in Ghana which found that most the women who participated in the study had experienced sexual violence. Opoku et al.'s (2016) study further found that as a result of sexual violence, the women are often faced with unwanted pregnancies, divorce and rejection. These findings are consistent with other studies that have found that most women with disability sexual violence at a point in time in their life (UNICEF, 2014; WHO, 2015).

Visibility of disability was found to be a significant predictor of violence and discrimination in the present study, whereas severity was not significant predictors of violence and discrimination. The finding on visibility did not support earlier research by Dammeyer and Chapman (2018) which found that visibility of disability was not a significant predictor of violence. This finding may be understood in terms of the social identity theory (Tajfel & Turner, 1979), in the sense that the visible characteristics of disabilities may cause people without disabilities to see those with disabilities as different. This may lead people without disabilities to treat those with disabilities differently. However, the finding on severity was consistent with Dammeyer and Chapman's (2018) study which found severity not to be a significant predictor of violence and discrimination.

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Similarly, the place of residence was found to be a significant predictor of discrimination among persons with disabilities, with reported discrimination being highest among rural residents. All forms of violence measured with the exception of humiliation and minor physical violence were highest among rural residents with disabilities. The findings are consistent with previous studies which similarly found that persons with disabilities in rural areas are relatively at a more disadvantage when compared to those in peri-urban and urban communities (Bock, 2015; Gartrell et al., 2017). For example, Gartrell et al. (2017) found that the rights of persons with disability in rural areas are unduly violated by several socio-cultural, physical and psychological factors within their environment when compared to their peers in urban areas.

The findings of this study, however, did not support Fiasorgbor and Ayagiyire (2015)'s study that found that perception and attitude towards persons with disabilities among rural residents were favourable. These findings suggest that persons with disabilities in rural areas are at an increased risk of violence and discrimination as compared to their colleagues in peri-urban and urban communities. This may be due to the fact that barriers facing people with disabilities are much harsher as compared to their peers in peri-urban and urban communities.

These findings emphasize the fact that disability increases the risk of violence and renders persons with disabilities particularly women more vulnerable to sexual violence. This is consistent with the process model which postulates that stressful conditions, the status characteristics and the environmental factors may heighten the risk of exposure to stressors (Pearlin, 1999).

A plausible explanation for the high level of violence and discrimination among persons with disabilities is that the nature of disability impedes one's ability to escape violence (Sobsey, 2014). Disability increases the risk of violence because it limits persons with disabilities' physical abilities, restricts their privacy, and at times renders them incarcerated. Aside from

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the fact that disability itself makes people vulnerable, other factors responsible for increased risk of violence among persons with disabilities includes socio-cultural attitudes and misconceptions about disability. Dako-Gyekye and Asumang (2013) argued that the forms of violence and discriminations faced by persons with disabilities in Ghana are mainly due the misconceptions, cultural beliefs and negative perceptions people have about mental disabilities.

According to the United Nations International Children's Emergency Fund (UNICEF) (2013), discrimination is not only as a result of a person's condition, but rather, an outcome of the lack of understanding of its causes and consequences, fear of difference or contagion, or religious/cultural perspectives of disability. To put this in the social identity perspective, violence and discrimination are as a result of categorization of persons with disabilities which may have led to the exaggeration of the difference between those with disabilities and those without any form of disability. This shows that there is the need for change, not only on the part of the person with a disability but the, but in social and cultural atmosphere that promotes helplessness on the part of persons with disabilities.

5.5 Practical Recommendations

This study has provided an overview of the different forms of violence and discrimination experienced by persons with disabilities in Ghana. The study will also help us understand the influence of violence and discrimination experienced by persons with disability on their psychological well-being. This will help develop specific strategies to prevent violence and discrimination. For example, the study has found the role of gender, religiosity and social support to be very important to the relationship between violence and discrimination, and psychological health.

Professionals working with people with disabilities must acknowledge the importance of religiosity and social support to people with disabilities. With the knowledge provided by this

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study, clinicians should develop culturally relevant strategies and interventions built around factors such as religiosity and social support that will mitigate the consequences of violence and discrimination on persons with disabilities. This will invariably help improve their health and quality of life.

Efforts need to be made to tackle misconceptions of Ghanaians about both physical and mental disabilities through informal and formal social education and training of the public and traditional healers. The findings of this study point to the fact that efforts should be made to empower women and girls with disability, and encourage religious institutions to challenge negative attitudes about disability and provide the necessary support for persons with disabilities.

The results of this study also point to the fact that there is a need to improve access to social protection in both rural and urban communities in Ghana. This must include schemes such as promoting inclusion and participation, provision of adequate services and provision of income security.

5.6 Limitations of the current study

Despite the current study's substantive contribution to the discussion on violence and discrimination, caution should be exercised in the interpretation of the findings due to the following limitations.

The first limitation of this study was that the respondents were selected from people with obvious disabilities and those who have been diagnosed with a disability. In doing so, people with severe activity limitations but no visible disabilities or diagnosis maybe have been overlooked. Also, persons with severe dementia and psychosis were not included in this study.

Secondly, findings were based on self-report measures, therefore no observational or interview data was gathered and responses might thus be socially desirable.

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The study conducted in only two regions of Ghana and also adopted a non-probability method of sampling, this should, therefore, be considered in interpreting the results.

Moreover, the sample size for this study is rather moderate hence the generalizability of these findings is quite limited.

5.7 Suggestions for Future Studies

There is a need for a nationwide survey with a larger sample size to help understand the real scope of the phenomenon of violence and discrimination among person with disabilities. Future studies should also consider a probability sampling technique to ensure samples used for the study are representative to the population of persons with disabilities.

5.8 Conclusion

The present study examined violence and discrimination experienced by persons with disabilities and their effects on their psychological health in Ghana. The study also specifically sought to examine factors that predict violence and discrimination among persons with disabilities, investigate how violence and discrimination impacts on psychological health, the moderating role of religiosity and gender as well as the role of social support in mediating the relationship between these factors.

The results suggest that persons with disabilities are more likely to experience all forms of violence and discrimination. The study further found the levels of all kinds of violence among people with mental disability to be significantly higher than those with physical disabilities. The current study also identified visibility and place of residence as significant predictors of violence and discrimination respectively. The study most importantly found violence to be a significant predictor of psychological health with discrimination being a predictor though not significant of psychological health.

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Additionally, a moderating effect of religiosity and gender on the relationship between violence and discrimination, and psychological health was found. Finally, the study found that social support moderated the relationship between violence and discrimination, and psychological health. The study provides evidence that a person's environment has a huge impact on the experience and extent of disability.

The overall findings are consistent with the process theory of stress, in the sense that violence and discrimination being stressors together with social and personal resources such as gender, religiosity and social support to affect an individual's psychological well-being. The findings of this study show that there is a lot to be done in order to deal with the phenomenon of violence and discrimination against persons with disabilities.

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APPENDICES

APPENDIX A: QUESTIONNAIRE

General Information about Research

The aim of this study is to examine the experience of violence and discrimination among persons with disability and how this can affect psychological health and well-being.

This study requires you to honestly answer a questionnaire about your experiences of violence and discrimination, and questions about your psychological health and well-being.

Answering the questionnaire will take you between 30 to 45 minutes.

Benefits

There are no benefits for your participation. However, the results of the study will help policy makers design specific strategies to prevent violence and discrimination among persons with disabilities. The study will also help develop culturally relevant strategies and interventions that will help clinicians to manage the consequences of violence and discrimination on persons with disabilities.

Risks of the study

One potential risk for this study is that, recalling experiences of violence and discrimination may evoke strong emotions. For this reason, there will a psychologist on standby to provide assistance to participants if the need arises.

Confidentiality

No identifying information will be requested from participants for this study.

After the collected data have been processed, electronic data will be stored on the laptop of the principal investigator with password to protect the data

The research team comprises of the principal investigator and the two of the study, and research assistants at the point of data collection may have direct access to research records.

Hence, by signing or thumbprinting a written consent form, you or your representative is authorizing such access.

Compensation

There will be no compensation for the participating in this study. Participation in this study does not come with any financial cost.

Withdrawal from Study

Participation for this study is voluntary and you may withdraw at any time without penalty. You will also not be adversely affected if you decline to participate or later stops participating.

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You or your legal representative will be informed as soon as possible if any information becomes available that may be relevant to your willingness to continue participation or withdraw.

Contact for Additional Information

If you want more information, questions or any other enquiry about this study, kindly contact the investigator

DANIEL AGYEI-KYEREMEH.

University of Ghana, Department of Psychology

+543213330

Email: agyeikyeremeh@gmail.com

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@isser.edu.gh / ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

Name of Participant

Signature or mark of Participant

Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Name of witness

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Signature of witness / Mark

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Name of Person who Obtained Consent

Signature of Person Who Obtained Consent

Date

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SECTION A: PHYSICAL AND MENTAL DISABILITY

This section seeks to gather information about your disability. Please fill out all sections as best you can.

1. Do you have a long-term physical health problem or disability? Yes No

2. If yes, please tick from the following categories the one that best describes your most **serious physical**?

Please check the box in front of the disability you have	
1. Motor and movement disorder such as cerebral palsy	<input type="checkbox"/>
2. Blindness and vision loss , despite the use of glasses or contact lenses	<input type="checkbox"/>
3. Deafness and impaired hearing , despite the use of hearing aids or cochlear implants; speech and language difficulties; dyslexia	<input type="checkbox"/>
4. Skin condition (such as vitiligo, Dermatitis, chronic skin infections) or Albinism	<input type="checkbox"/>
5. Allergies and breathing difficulties (Asthma)	<input type="checkbox"/>
6. Chronic conditions and progressive diseases such as renal disease, rheumatoid arthritis and cancer	<input type="checkbox"/>
7. Other health problem or disability (any physical disability that ca not be classified under any of the above options)	<input type="checkbox"/>

3. Do you have one or more mental disorders or disabilities? Yes No

4. If yes, please tick from the following categories the one that best describes your **Mental Disability**

Please check the box in front of the disability you have	
1. Mental disorder caused by alcohol or substance use (such as Substance-induced anxiety disorder, Substance-induced mood disorder)	<input type="checkbox"/>
2. Schizophrenia and psychosis	<input type="checkbox"/>
3. Mood disorders including depression and bipolar disorder	<input type="checkbox"/>
4. Stress, phobias, anxiety, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) Personality disorders	<input type="checkbox"/>
5. Autism spectrum disorders	<input type="checkbox"/>
6. Attention deficit hyperactive disorder (ADHD) or similar disorder	<input type="checkbox"/>
7. Other mental disorders (any mental disorder that cannot be classified under any of the above options)	<input type="checkbox"/>

SECTION A3. SEVERITY AND VISIBILITY

1. How would you classify your disability?

Minor Major

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2. Would a stranger recognize within five minutes that you have a disability/health problem/mental disorder?

Always Sometimes Never

SECTION B1. VIOLENCE

In this section, we want to know about your experiences of violence within the **past year**. Remember it should have occurred within one year.

	YES	NO
1. In the <u>past year</u> , has someone threatened you with violence?		
2. In the <u>past year</u> , has someone humiliated, degraded or ridiculed you, or constantly criticized you?		
3. In the <u>past year</u> , has someone prevented you from accessing your own money or Mobile money wallet, or forced you to pay a sum of money, or forced you to do anything against your will?		
4. In the <u>past year</u> , has someone shaken you, pushed you or pulled your hair?		
5. In the <u>past year</u> , has someone hit or kicked you?		
6. Have you shaken, pushed, hit or kicked another person within the <u>last year</u> ?		
7. In the <u>past year</u> , has someone forced you to kiss or hug?		
8. In the <u>past year</u> , has someone forced you to have sexual intercourse or engage in other sexual acts?		
9. In the <u>past year</u> , has someone fondled you (grabbed you in a sexual manner, touched you in a private part like your breast, penis, or buttocks)?		

SECTION B2. DISCRIMINATION

Discrimination occurs when people are unfairly treated because they are perceived as different from others.

1. Do you feel that you are discriminated against because of your disability? Yes No

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SECTION C: MSPSS

In this section, we want to know how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

1= **Very Strongly Disagree**, 2= if you **Strongly Disagree**, 3= if you **Mildly Disagree**, 4= if you are **Neutral**, 5= if you **Mildly Agree**, 6= if you **Strongly Agree**, 7= if you **Very Strongly Agree**

1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

SECTION D: SCSORF

Please answer the following questions by selecting the one that best applies to your religious life.

1. Strongly Disagree 2. Disagree 3. Not Really 4. Agree 5. Strongly Agree

1. My religious faith is extremely important to me.	1	2	3	4	5
2. I pray daily.	1	2	3	4	5
3. I look to my faith as a source of inspiration.	1	2	3	4	5
4. I look to my faith as providing meaning and purpose in my life.	1	2	3	4	5
5. I consider myself active in my faith or church.	1	2	3	4	5
6. My faith is an important part of who I am as a person.	1	2	3	4	5
7. My relationship with God is extremely important to me.	1	2	3	4	5

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8. I enjoy being around others who share my faith.	1	2	3	4	5
9. I look to my faith as a source of comfort.	1	2	3	4	5
10. My faith impacts many of my decisions.	1	2	3	4	5

SECTION F: BSI -18

In this section, there is a list of problems people sometimes have. Please read each one carefully, and **circle** the number that best described you during the **past 7 days including today**.

0 is Not at All, 1 is Rarely/Occasionally, 2 is Sometimes, 3 is Often, and 4 is Very Often.

In the past seven days including today how much were you distressed by

1. Faintness or dizziness	0	1	2	3	4
2. Pains in heart or chest	0	1	2	3	4
3. Nausea or upset stomach	0	1	2	3	4
4. Trouble getting your breath	0	1	2	3	4
5. Numbness or tingling in parts of your body	0	1	2	3	4
6. Feeling weak in parts of your body	0	1	2	3	4
7. Feeling no interest in things	0	1	2	3	4
8. Feeling lonely	0	1	2	3	4
9. Feeling sad	0	1	2	3	4
10. Feelings of worthlessness	0	1	2	3	4
11. Feeling hopeless about the future	0	1	2	3	4
12. Thoughts of ending your life	0	1	2	3	4
13. Nervousness or shakiness inside	0	1	2	3	4
14. Feeling tense or keyed up	0	1	2	3	4
15. Suddenly scared for no reason	0	1	2	3	4
16. Spells of terror or panic	0	1	2	3	4

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17. Feeling so restless you couldn't sit still	0	1	2	3	4
18. Feeling fearful.	0	1	2	3	4

SECTION G: DEMOGRAPHICS

Please tick the appropriate box and where needed please write the required response.

1. Gender: 1. Male 2. Female

2. Age: _____

3. Religious affiliation: 1. Christian 2. Muslim 3. Traditionalist 4. Other
5. No religious affiliation

4. Place of residence: 1. Urban 2. Rural 3. Peri-urban

5. Name of next biggest town _____

6. Highest Educational level: 1. No formal education 2. Primary school

3. Secondary school 4. First degree 5. Masters 6. PhD

7. Marital Status: 1. Unmarried 2. Married 3. Widowed

8. What is your current employment status? Tick the one that applies.

1. Employed full time	
2. Employed part time	
3. Unemployed and currently looking for work	
4. Unemployed and not currently looking for work	
5. Student	
6. Retired	
7. Self-employed	
9. Unable to work	

END OF SURVEY!

Thank You for taking part in this survey

APPENDIX B: ETHICAL



UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

28th March, 2019

Dr. Annabella Osei-Tutu
Department of Psychology
University of Ghana
Legon

Dear Dr. Osei-Tutu,

ECH 091/18-19: VIOLENCE AND DISCRIMINATION AMONG PERSONS WITH DISABILITY IN GHANA.

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 21/03/20
On Agenda for: Initial submission
Date of Submission: 15/01/19
ECH Action: Approved
Reporting: Annually

Please accept my congratulations.

Yours Sincerely,

Prof. C. Charles Mate-Kole.
ECH Vice Chair

